

State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

South Carolina

Summary: In 2011, South Carolina was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals*. As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The South Carolina Department of Health and Human Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., E.T. June 28, 2012. You may submit comments on this proposal to SC-MedicareMedicaidCoordination@cms.hhs.gov.

State of South Carolina
Department of Health and Human Services

**Proposal to the
Center for Medicare & Medicaid Innovation**

**State Demonstration to Integrate Care
for Dually Eligible Individuals**

May 25, 2012

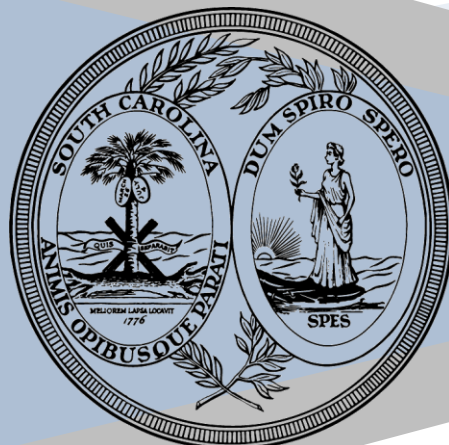


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A. Executive Summary

The South Carolina Department of Health and Human Services (SCDHHS) is one of 15 states with an 18-month planning grant from the Centers for Medicare and Medicaid Services (CMS) to develop a service delivery model that integrates care for individuals who receive services from both Medicare and Medicaid.

Demonstration

The South Carolina Dual Eligible (SCDuE) Demonstration Project provides the opportunity to address the weaknesses in the current system by realigning incentives to allow Medicare and Medicaid services to work in a single system. In addition, through shared savings, the State will be able to focus on preventative services and on delaying or eliminating the need for more costly institutional long-term care (LTC), and avoidable emergency department visits and hospital stays. Specifically, the State plans to:

1. Encourage all providers to make significant progress towards becoming a certified Patient-Centered Medical Home (PCMH);
2. Ensure care coordination and planning by an multidisciplinary team with a focus on the needs of people dually eligible for Medicare and Medicaid;
3. Provide a seamless system of care with access to physical health, behavioral health, and long-term supports and services (LTSS) with a consumer direction component for personal services;
4. Keep the home-and community-based waiver system outside of the capitated payment, but fully integrate it with the multidisciplinary team for care coordination and planning;
5. Ensure choice of health plan with a robust network and guide participants to select a demonstration plan assisted by an independent, conflict-free enrollment broker;
6. Commit to providing home and community-based services (HCBS) for everyone in the Demonstration who meets service criteria without regard to a waiting list; and
7. Commit to payment reforms that adequately address the care management fee and cost sharing with providers that meet targeted goals.

Table A.1.Demonstration Elements Overview Chart

Target Population	<ul style="list-style-type: none"> – Full benefit dual eligible (Medicare & Medicaid) – 65 years of age and older – Non-institutional (including <u>all</u> HCBS waivers) at time of enrollment – No exclusions based on diagnosis or condition(s) – Excludes PACE participants
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	– 131,090
Total Number of Consumers Eligible for Demonstration	– 68,000
Geographic Service Area	– State wide with a phased-in implemented across two geographic areas (based on projected population).

Summary of Covered Benefits	<ul style="list-style-type: none"> – Medicaid State Plan services including nursing facility and behavioral health services – Medicare Parts A, B, and D – LTSS (FFS) coordinated through CICO
Financing Model	<ul style="list-style-type: none"> – Capitated
Summary of Stakeholder Engagement/Input	<ul style="list-style-type: none"> – SCDuE Integrated Care Workgroup (ICW) and focused sub-groups meetings – SCDuE Web Site – 3 Public Meetings
Proposed Implementation Date(s)	<ul style="list-style-type: none"> – October 1, 2013 – Open Enrollment Region-1 – January 1, 2014 – Service starts Region-1 – April 1, 2014 – Open Enrollment Region-2 – July 1, 2014 – Service starts Region-2

Target Population and Geographic Service Area

This proposal will focus on full dual eligible South Carolinians 65 and older not residing in a nursing facility at the time of enrollment in the Demonstration. At the time of implementation, approximately 68,000 individuals are expected to meet the eligibility criteria. The SCDuE implementation will be phased-in over two geographical regions. Phase I enrollment begins in October 2013 for Region-1, and Phase II enrollment begins in April 2014 for Region-2. Services for Phase I (Region-1) enrollment begin in January 2014, and July 2014 for Phase II (Region-2) enrollment. Figure B.1 provides an illustration of the phased-in enrollment by geographic regions. Therefore, services will be available statewide by July 2014. The proposed geographic rollout prioritizes regions with the highest proportion of non-institutional dual eligible consumers while allowing for the development of comparable primary care, behavioral health and community-based and long-term care (LTC) services for statewide implementation.

Financing Model

SCDuE will utilize the CMS Capitated Financial Alignment mechanism and will engage in three-way contracts between the federal government, the State and management entities. The management entity will be a coordinated and integrated care organization (CICO) that will be the primary vehicle for delivery and management of services for this Demonstration including extensive care coordination activities. Although during this Demonstration, HCBS waiver services are not included in the capitated rate, the PCMH care coordinator must ensure LTC assessment of needs and services are integrated into the care plan with waiver case managers included as an integral part of the multidisciplinary team.

Summary of Covered Benefits

The SCDuE Demonstration will include a full continuum of Medicare and Medicaid services to consumers that are fully managed, coordinated and authorized through the CICO and its PCMH. LTCSs will be coordinated through the SCDHHS, Bureau of Community Long Term Care.

Summary of Stakeholder Engagement/Input

Strategic planning, which included a team of private and public stakeholders and subject matter experts from across the health care services and public policy arenas, was initiated in July 2011 and continued through March 22, 2012. The engagement of stakeholders included formal meetings with work group members, conference calls, key informant interviews, meetings of

advocates and consumers, a 30-day public comment period, and three public meetings around the state.

B. Background

South Carolina proposes to develop a multi-phased design and implementation plan for innovative service delivery models that integrate care for individuals who receive services from both Medicare and Medicaid. The award of a planning contract to SCDHHS was effective in April 2011 with guidelines that have evolved over the last 11 months. SCDHHS is responsible for Medicaid health plan, behavioral health, and home and community-based and institutional LTC services.

SCDuE is developing during a transformation in South Carolina's Medicaid coordinated care programs that is driven by SCDHHS's Medicaid Coordinated Care Improvement Group (CCIG). This proposal builds on key tenets of the SCDHHS's Medicaid Coordinated Care Improvement Group (CCIG) to frame the approach for this Demonstration. See Appendix A for a description of the CCIG.

i. Barriers to Address

South Carolina has few programs that coordinate care across Medicare and Medicaid funding streams. Contributing to this are financial disincentives for states to coordinate this care. Medicaid initiatives to reduce inpatient hospital stays will, if successful, reduce Medicare expenditures for dually eligible consumers. Similarly, Medicare efforts to reduce institutional long-term care services benefit Medicaid programs much more than Medicare for duals.

In addition, while there are many positive components in the State Medicaid system, they tend to be isolated and not coordinated across long-term care, primary care and behavioral health services. There is very little systematic coordination of care so that information gathered in one area can be shared with other providers in developing and implementing treatment plans.

With the exception of the State's two Programs for All-Inclusive Care for the Elderly (PACE), there has been no effort to integrate long-term care services with primary care and behavioral health services. While the PACE programs have been successful, the two programs only cover four of South Carolina's 46 counties and provide care to fewer than 500 consumers. The State needs to develop programs that can provide this level of integrated care to a broader population on a statewide basis.

Finally, the HCBS waiver programs have been successful and have seen substantial growth in recent years. Waiver slots have increased and South Carolina has reduced the nursing facility waiting list to historical low levels. This policy shift ranks South Carolina among the leaders in appropriate use of home and community based services. This Demonstration will continue to advance efforts to provide less costly care options in the least restrictive setting.

This Demonstration provides South Carolina the opportunity to address the weaknesses in the current system by realigning incentives to allow Medicare and Medicaid services to work in a single system. Additionally through shared savings, the State can focus on preventative services and on delaying or eliminating the need for more costly institutional LTC and avoidable hospital stays.

ii. Description of Target Population

This proposal will focus on full dual eligible South Carolinians 65 and older not residing in an institutional setting at the time of enrollment. Those enrolled in the PACE program will be excluded from the target group. As determined by their individual needs, South Carolina will allow enrolled dual eligible residents to have full access to long-term care and nursing facility services. In calendar year CY2009, approximately 54,900 persons were part of this proposed target population. See Appendix B for details. This estimate is based on the CY2009 Medicare 5% sample file.¹ Given projected growth in both the state population and the Medicaid eligible population by 2014, South Carolina expects the target population to number approximately 68,000 at the time of implementation.²

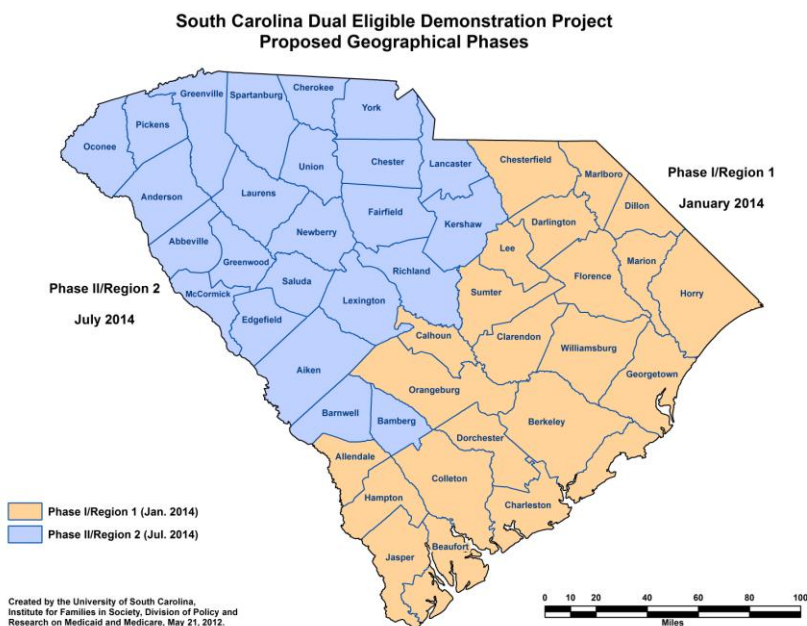
Regional Geographical Distribution of SCDuE Implementation Population

The SCDuE implementation will divide the eligible population into two geographical regions. See Figure B.1 for details.

¹ This sample file provides a representative sample of 5% of fee-for-service Medicare consumers, excluding individuals in PACE and managed care (Medicare Advantage) from this analysis. The dual population was identified through enrollment information indicating that the state pays the Medicare Part A and/or B premiums. Using the state buy-in indicator and the state of residence, the enrollment and claims information was extracted for CY2007 through 2009.

² This figure underestimates the population eligible for enrollment in the implementation. It is calculated using the South Carolina 2014 Census projections for individuals 65 and over divided by the three-year mean of the percent of the total population identified as dual eligible in CY2007-2009. The projected target population will be updated, as more current data is available through the Data User Agreement between CMS and South Carolina. Current projections for South Carolina indicated a two to five percent growth of the South Carolina population aged 65 and above.

Figure B.1. SCDuE Demonstration Project Proposed Geographical Phases



These regions represent different geographical segments of the full dual eligible target population. Enrollment in the Demonstration will occur in two rollout phases. See Figure B.1 for details. As described in the above sections, Phase I enrollment begins in October 2013 for Region-1, and Phase II enrollment begins in April 2014 for Region-2. Services for the Phase I (Region-1) enrollment begin in January 2014, and July 2014 for the Phase II (Region-2) enrollment. The proposed geographic rollout prioritizes regions with the highest proportion of non-institutional dual eligible consumers while allowing for the development of comparable primary care and behavioral health services for statewide implementation.

The target population represents a diverse group of individuals classified as dually eligible due to differing economic and medical needs. The Coastal area of South Carolina (Region-1) has the fastest growing segment of the target population using HCBS. As a group, they have a high prevalence of chronic conditions prior to movement into institutional level of care.³ In contrast, the Upstate (i.e., the northwestern part of Region-2) has the largest segment of the population qualifying for Medicaid services only upon eligibility for institutional level of care (waiver or nursing facility care). The Midlands or Central South Carolina (i.e., the lower portion of Region-2) has a balanced population meeting Medicaid eligibility prior to and upon entry into institutional level of care.

a. Target Population Diagnostic Profile

Based upon CY2009 claims and encounter data derived from the Medicare 5% sample file, South Carolina summarized the data by disease occurrence corresponding to the Chronic Illness and Disability Payment System (CDPS)-Medicare model diagnostic categories. Appendix C

³For purposes of this proposal, institutional level of care qualifies a recipient for nursing home placement or meeting medical nursing home criteria.

(Table B.2) provides a breakdown of the disease occurrence of the proposed target population. Approximately 89% of this population was classified into a diagnostic category and risk status at the high and medium classification levels ranging from very low to very high projected disease burden costs.

Appendix C (Table B.2) illustrates the diverse diagnostic profile of the non-institutional subset of the target population with implications for acuity and care setting. Approximately 7% of the non-institutional target population presented with psychiatric primary diagnoses requiring the integration of services aimed at addressing their physical and behavioral health care needs. It is anticipated that this number will be proportionally higher for those above the age of 75 and those residing in a nursing home with diagnosis of dementia. This population will require a network of providers that can integrate behavioral health and LTSS across a continuum of needs.

Analyses of the activities for daily living (ADLs) indicate approximately 31% of the population aged 65 and above require assistance with two or more ADLs. See Appendix D (Table B.3) for details. This distribution captures the *Current Population Survey Annual Social and Economic Supplement* membership information from the 5% sample. It extrapolates to the total population above age 65, suggesting a higher prevalence of ADLs associated with the full dual eligible Demonstration target population. South Carolina's level of care (LOC) designations are relatively stringent compared to other states and would require deficits in several of the ADLs to qualify at the nursing home level of care.

There will be no exclusions to enrollment based on diagnoses (e.g. ESRD, ventilator-dependent, HIV/AIDS, terminally ill, ID, etc.).

b. Service Utilization and Costs

Service utilization per 1,000 by age groups differs for the target population as a function of residential setting.⁴ See Appendix E (Table B.4) for details. In the non-institutional setting, the use of nursing facility, inpatient hospital, emergency department, and home health services increases with advancing age. Conversely, behavioral service utilization is highest for the non-institutional population under the age of 74 regardless of the residential status. The data supports the need for an integrated continuum of care encompassing enhanced medical, caregiver support, integrated behavioral, home and community-based, and nursing facility services, including inpatient rehabilitation and hospice care.

Predictably, the service utilization per 1,000 for the institutional population is higher for nursing home, inpatient hospitalization, durable medical equipment, and laboratory services with lower use of behavioral health services. See Appendix F (Table B.5) for details. Preliminary analysis of historical Medicare Part D data indicated the institutional population ages 65 and above has the highest PMPM pharmacy claims (\$456) compared to younger disabled (\$423) and non-institutional aged (\$315) categories.

C. Care Model Overview (CICO/PCMH)

i. Delivery Model/System/Programmatic Elements

⁴ Institutional claims do not include short stays at a skilled nursing facility.

SCDHHS's mission is to purchase the best health care for consumers enrolled in Medicaid for the least cost to South Carolina's citizens. Several current initiatives, including SCDuE, are moving SCDHHS and the configuration of the State's Medicaid program toward improved health care, improved health and lower overall costs; therefore, it is important to coordinate these initiatives so that goals, processes and outcomes align for efficiency and effectiveness of the total system of care. Throughout the planning process, all stakeholder groups have expressed concern about ensuring access to appropriate services for consumers and valuing the strengths of the current system. They also have voiced support for an integrated and coordinated system of care for individuals who are dually eligible and could benefit from the following core elements of an integrated system:

- Strong, person-centered care based in accountable primary care medical homes;
- Multidisciplinary care teams that use a "holistic approach" and coordinate the full range of medical, behavioral, and long-term supports and service needs across settings;
- Comprehensive provider networks capable of meeting that full range of needs;
- Enhanced use of home and community-based long-term care services with access to institutional care as needed when all other options are exhausted;
- Robust data sharing and information systems to promote care coordination, monitoring and quality reporting;
- Strong consumer protections that ensure access to established providers and involve consumers in program design;
- Financial alignment that supports integration of care, management of costs and incentives for improved quality care; and
- Care management processes that reduce provider administration burden.

SCDuE is being designed with an emphasis on a new and expanded form of coordinated and integrated care in South Carolina. It builds on evidenced-based practices and incorporates the principles of a patient-centered medical home model; increasing emphasis on primary and preventive care; applying best practices in care coordination and medical management with team-based care; emphasis on a holistic approach; increasing utilization of health information technology to support patient care, quality and safety; and payment structures that support the added value in this enhanced form of care.

a. Coordinated and Integrated Care Organization (CICO)

SCDuE will utilize the CMS Capitated Financial Alignment mechanism and will engage in three-way contracts between the federal government, the State and management entities. The management entity will be a coordinated and integrated care organization (CICO) that will be responsible for delivery and management of all covered services for this Demonstration including extensive care coordination activities. For the purposes of this Demonstration, CICOs are organizations (e.g., Managed Care Organizations (MCOs) and Care Coordination Service Organization (CSOs)) that can meet all applicable conditions that will be outlined in the Request for Information/Solutions (RFI/RFS) released in early Summer 2012, as well as requirements mutually established by the State and CMS that will be included in the procurement documents released in Fall 2012. At a minimum, organizations bidding to be a CICO must have the capacity to bear risk, meet the requirements of the South Carolina Department of Insurance, and to contract with a variety of providers to provide, arrange for, and/or coordinate the full continuum

of services including primary and behavioral health care, specialists, hospitals, and institutional care. See Appendix G (Figure C.1) for an illustration of the CICO proposed model. Although during this Demonstration, HCBS waiver services are not included in the capitated rate, the PCMH care coordinator is responsible for ensuring that the LTSS assessment of needs and services are integrated into the care plan and that the waiver case managers are included as an integral part of the multidisciplinary team.

Care delivery will be anchored in a PCMH, guided by a multidisciplinary care team, and tailored to plan for and address individual needs through enhanced care coordination. CICOs, therefore, must be capable of utilizing and managing a care delivery model centered in a PCMH. The contractual relationship between the CICO and PCMH will outline responsibilities of both ensuring ultimate accountability residing with the CICO. They also will be required to demonstrate core competencies in PCMH, integrated care, behavioral health services, and LTSS as they will need to facilitate and support the development of PCMH skills in some practices. Medical homes will be encouraged to achieve National Committee on Quality Assurance (NCQA) PCMH Recognition at Level-1 or higher within the Demonstration period. The CICO will develop a reimbursement structure that will include enhanced payments to the PCMHs to deliver integrated and coordinated care as required for this Demonstration. To ensure adequacy of PCMH providers, the CICO will develop alternative payment strategies (e.g., incentives) to encourage development of PCMH standards and certification.

Since HCBS are not incorporated into the capitated rate, the State must ensure these services are coordinated and seamless to the consumer. In structuring services in this manner, the State seeks to build upon its existing infrastructure for providing HCBS and to coordinate LTSS with those provided by the CICO. This will allow the CICO to focus on developing medical homes and behavioral health networks across the state in the initial phase of the Demonstration. In making this decision, the State considered the following:

- Since 2007, South Carolina has served more people in Community Choices, the waiver for the elderly and persons with physical disabilities, than are served under Medicaid sponsorship in nursing facilities. This emphasis on HCBS continues to grow, with ongoing gubernatorial and legislative support in continuing to add slots to the waiver program. South Carolina's recent reactivation of its Money Follows the Person (MFP) Grant is further indication of this commitment to rebalancing its Medicaid LTSS.
- Waiver services cover a wide range of areas including traditional HCBS, such as personal care adult day care, and a more innovative technology-based service, telemonitoring, which provides web-based daily reporting on vital signs to medical professionals.
- These services are provided by a large number of enrolled and contracted Medicaid providers. HCBS waivers are able to offer service choice even in the most rural areas of the State.
- South Carolina has been a national leader in using electronic technology to support HCBS. The State has two well-developed software systems, *Phoenix* and *Care Call*, which provide automated support for waiver operations. See Appendix H and I for full descriptions of these systems. These integrated systems provide support for all components of the HCBS waiver operation, from initial assessment through billing of services. CMS has cited both systems as best practices. Together, they provide electronic records for all waiver assessments, care

plans, service authorizations, provider information, service delivery documentation, caregiver support systems, real time monitoring of service provision, and numerous other components to support administration, case management and quality assurance activities.

- South Carolina has a well-established, self-directed care component in most of its waivers for adults, enabling many family members and informal supports to serve as paid caregivers. Financial management services are integrated into the *Care Call* and *Phoenix* systems to ensure quick and accurate payment to caregivers and for monitoring service provision.

Even though South Carolina has provided waiver services since it was one of the initial HCBS Demonstration states in the late 1970s, these services have not been well coordinated with primary care and behavioral health services. The State is committed to developing a system that will provide this coordination in a way that is seamless and transparent to consumers and ensures that information is shared in a timely manner to support integrated efforts and enhanced services. Most importantly, this Demonstration will provide for the coordination between HCBS and the CICO to remove any barriers to accessing waiver services by taking the following steps to meet this assurance:

1. Whenever there is an indication that LTSS are needed, the CICO/PCMH care coordinator will be given secured access to *Phoenix* to make an electronic referral. From this point forward, the CICO can view all waiver records related to this consumer.
2. SCDHHS will contact the consumer and conduct a brief phone assessment. An appointment for an in-home assessment will be scheduled at this time.
3. Contingent upon the results of the assessment and level of care screening, the consumer will be admitted to the waiver program. A waiver case manager, and where appropriate, an MFP transition coordinator will work with this consumer in developing a care plan and authorizing waiver services for integration into the overall plan of care. All referrals received will be processed without regard to a waiting list so that services can be initiated as soon as the eligibility determination is completed.
4. With regards to the Home Again Program (i.e. Money Follows the Person (MFP)), in collaboration with the waiver case manager and the CICO, the MFP transition coordinator will connect with consumers seeking assistance transitioning from an institutional setting to one that is community-based.
5. All waiver services will be documented using the State's *Care Call* system.
6. The CICO/PCMH care coordinator will be able to access all waiver records including all assessments conducted for the waiver enrollment, care plans created, services authorized, service delivery documentation, family and other caregiver supports (including stress assessments of key caregivers) information, annotation of all prescription and over-the-counter (OTC) medications as documented during in-home visits, and assessments of environmental conditions and other key data. All of this information will be available in a timely manner to members of the care coordination team. Electronic notifications will be made to the care coordinator whenever updates are made to the *Phoenix* records.
7. SCDHHS also is implementing a system whereby personal care and adult day care providers will be able to report electronically any changes in the waiver participant's conditions or significant events that result in updating the care plan. Most often, it is the in-home providers, such as personal care workers, who see the participant on a daily basis and are best able to identify critical changes (i.e., weight gain/loss, changes in cognitive behavior,

functional declines, etc.) and events (i.e., falls, hospitalization, significant caregiver illness or disability, etc.). Reporting this information will become part of the *Care Call* documentation of services.

8. The waiver case manager will serve on the care coordination team and provide input into any LTC related services. The case manager also will assist in incorporating the waiver service plan into the overall care plan. When the CICO becomes aware of changes that would affect the level of services needed, the case manager will receive this information and make necessary updates to reflect both short-term and long-term changes in the consumer's condition. By having the waiver case manager as part of the team, the State assures continuity of care and that services are seamless and transparent to the consumer. This process also assures that someone outside of the CICO will be responsible for authorizing the needed levels of services. Waiver case managers who participate on the care management team will receive additional training in holistic care integration and must demonstrate the skills necessary to be a contributing member to this team. Requirements and penalties will be established to ensure active participation in the care team.
9. Finally, if there is disagreement between the CICO and waiver case manager on the amount of LTSS, a process will be developed for arbitration/review by the State to ensure timely resolution.

The State understands that the CICO will need to maintain financial incentives to reduce nursing facility placements. The State does this by including nursing facility care in the package of coverage provided by the CICO. This aligns the financial interests of the CICO and the State in providing nursing facility care when needed, but only when other home-based options are not sufficient to sustain the consumer in the safest, least restrictive setting.

Currently, there are 150 Medicaid contracted nursing facilities in South Carolina. The state has a Medicaid Permit Day law that specifies how patient days are allocated to facilities. The state has not funded any newly constructed Medicaid nursing facility beds in over twelve years. In February 2012, CMS approved an enhanced nursing facility rate for persons who have complex medical conditions. This sub-acute level of care was developed to provide adequate reimbursement for a higher acuity level for hospitalized persons who were having difficulty being placed in a nursing facility.

Since July, SCDHHS has initiated a collaborative effort between hospitals and nursing facilities to monitor the bidirectional flow of residents to and from these two facility types. The goal is to ensure timely access to nursing facility care and to avoid preventable and unnecessary readmissions from nursing facilities to hospitals.

Once admitted to a nursing facility, it is the intent of this demonstration that the CICO will continue to provide care coordination to avoid unnecessary medical costs such as hospitalizations and prescription drugs. Care coordination also will be used to determine if the nursing facility resident can appropriately be transitioned back to the community.

b. Geographic Service Area

Although SCDuE will begin implementation on a regional basis, it will operate statewide by July 2014. Region-1 will implement services beginning January 2014. Region-2 will implement

services beginning July 2014. The statewide geographical area will ensure sufficient consumers to guarantee access to care and choice of plans across all regions of the state. Organizations will be selected to ensure that consumers have the choice statewide of at least two CICOs. Selected CICOs must demonstrate the capacity to serve the entire state within that timeframe. See pages 5-6 for a more detailed discussion on the state geographical service area and proposed phase-in of the Demonstration.

c. Enrollment Methods

Enrollment will occur in two phases. See Figure B.1 for details. Phase I open enrollment will begin in October 2013 in the coastal regions (Region-1) with start-up of the Demonstration in January 2014. Phase II (Region-2) will start enrollment in April 2014 with services beginning in July 2014. Enrollment protocols and network certification will be complete at least three months prior to the enrollment in each of the proposed phases to help prevent disruption of access to care. SCDHHS will contract with an independent Enrollment Broker that will assist consumers in selecting the best SCDuE plan based on existing relationships with service providers and identified health care needs.

The SCDuE Demonstration proposes a passive enrollment process in which the consumer may choose to opt out before the end of a 90-day trial period. This enrollment process provides individuals the opportunity to choose the integrated and coordinated care service delivery options. However, if no choice is made, individuals will be passively enrolled into one of the CICOs with the opportunity to opt-out before the end of the 90-day trial period. Unless indicated for medical reasons, the CICO will provide appropriate care during this period, and any consumer already receiving services via Medicaid or Medicare will not experience any reduction to his or her service plan or changes to providers or pharmaceuticals during that time period. Consumers who do not opt out before the end of the trial period will continue to receive services through the CICO. All consumers will have an annual opportunity for disenrollment from the program. Primary Medicare consumers may opt-out to a Medicare Advantage Plan or fee-for-service (FFS). Primary Medicaid consumers may opt-out to any of the Medicaid Managed Care Organizations (MCOs) or Medical Home Networks (MHNs).

Ensuring sufficient enrollment is a key aspect in developing an improved service delivery system and offering consumer choice of CICOs with adequate provider networks. Redesigning the complex system of care so that it integrates and coordinates services to address the needs of the “whole person” is tremendously challenging and only will occur if there is a critical mass ready to use the better system. The opt-out enrollment option provides choice for the consumers. Passive enrollment with the “opt-out” feature balances the need for consumer choice and the need for additional protections consistent state and federal requirements [with the need for sufficient enrollment (lock-in period)]. For consumers not capable of making a choice, family caregivers will be allowed to assist in this process. This system moves consumers into coordinated and integrated care to provide a sufficient number of consumers necessary to support a robust provider network and care coordination system. CICOs will be encouraged to include additional benefits that will encourage consumers to choose the coordinated and integrated care delivery option and develop consumer loyalty so they continue participation once enrolled.

d. Outreach and Marketing

Ensuring consumers receive timely and accessible information on the network and covered services changes and their options will be an essential part of the enrollment process. Clear and transparent access to unbiased information is crucial to ensuring consumers have the opportunity to make informed decisions. To simplify the process, SCDuE's enrollment will be integrated with the Enrollment Broker process for SC Medicaid so that the access is seamless, easy to identify and encompasses the needed consumer protections that are discussed further in Section D of this document. This process will ensure consumers have advance notice with an upfront option for opting out. The Enrollment Broker will develop easy to understand materials in appropriate and alternative formats that meet the needs of the target population (e.g., low reading level, alternative language, or visual challenges).

Each CICO will be required to develop a comprehensive marketing plan and submit it to the State and CMS for approval. All materials for dissemination to potential consumers or the public must first be approved by the State and CMS to ensure accuracy. The State will actively promote the benefits of this Demonstration and will work with advocacy and community organizations, members of the Integrated Care Workgroup (ICW), the Lt. Governor's Office on Aging and its network of Aging and Disability Resource Centers and the State Health Insurance Program (SHIP) as outreach and education partners to provide information, education and referral to their constituencies to ensure awareness and understanding of the benefits of the program.

e. Provider Network Adequacy and Access

CICOs must demonstrate the availability of an adequate provider network as defined by SC DHHS and CMS for this population. SC DHHS will require CICOs to establish and maintain a network of providers, either directly or through a subcontract that assures access to all population-appropriate Medicaid and Medicare benefits, as well as to any supplemental benefits covered in this Demonstration. The networks must include a broad array of providers including primary care providers, specialists, hospitals, care coordination providers, community health workers, behavioral health providers, pharmacies, and providers of institutional long-term care services. Options for integrating specialists who can be deemed as primary care providers (such as cardiologists or other specialists that the consumers utilize to coordinate their care), as well as the traditional primary care providers such as general and internal medicine practitioners, will be explored with CMS.

To ensure continuity of care and eliminate barriers to consumer choice of the CICO, SCDHHS will require CICOs to conduct outreach to recruit current medical and behavioral health providers of eligible consumers. Provisions must also be made to continue existing out-of-network relationships in cases where a person is undergoing active treatment for a specific condition. The CICO must pay the provider during the course of treatment until the provider releases the consumer from continued treatment and follow-up. CICOs must ensure that providers in their networks have demonstrated expertise with complex geriatric populations, will accept new Medicaid/Medicare patients, and are multi-lingual and culturally relevant to their communities. The CICO must establish provider networks that meet the standards for provider access in federal Medicaid managed care regulations, access for LTC services, and Medicare access standards for medical services and prescription drugs. They must ensure access to continuous and appropriate care as well as the level of care needed to avoid an inappropriate

disruption in services (e.g., rehabilitation). In providing these services, the CICO and providers must comply with the Americans with Disabilities Act (ADA) and all other applicable Federal requirements. CICOs must work with providers to demonstrate the capacity to deliver services in a manner that accommodates the unique needs and disability characteristic of this population.

CICOs will be required to continuously monitor network adequacy and adherence to access requirements. They will provide monthly reports to SCDHHS in a format to be designated. In addition, the CICO will conduct a formal status briefing in a pre-determined format to both SCDHHS and any interested party on a quarterly basis and will allow for public input at these meetings. CICOs will analyze their network adequacy on a quarterly basis and immediately identify gaps and develop recruitment strategies to fill those gaps. This gap analysis is designed to identify the reasons for the gaps in networks and corrective strategies to address access to care. CICOs will be responsible for managing their networks including providing appropriate provider education, provider credentialing, establishing and tracking quality improvement goals, conducting site visits and medical records reviews. The CICOs are responsible for complying with incentives set by State and Federal guidelines for providers to improve health outcomes, including deinstitutionalization. In addition, the CICOs will audit a certain percentage of medical records each quarter to ensure the providers are maintaining the medical records as required.

ii. Benefits Design

The SCDuE Demonstration is designed to significantly enhance the individual's experience with the entire health care system. This care coordination model is intended to fundamentally transform the manner in which health care is provided to persons who are dually eligible, particularly those with more complex care needs, such as a terminal illness, requiring in-patient rehabilitation or dialysis. SCDuE will provide seamless access to a robust package of services that includes all physical health services (acute, specialty and primary), behavioral health and addictive disorder services, and LTC services that are covered by either Medicare or Medicaid. Additional services include: PCMH care coordination, multidisciplinary team, comprehensive assessment, behavioral health screening, care plan development, and clinical care management. Services will be integrated through a comprehensive care plan focused on the "whole person." Integration is achieved through enhanced coordination and communication between service providers, health information technology that facilitates proactive and preventive care management, easy exchange of information, integration of medical, behavioral, and LTSS records in a shared electronic medical record and multidisciplinary approaches to care planning, management and treatment. Integration occurs at various levels. A high level of integration can occur through co-located providers who utilize "warm handoffs" of patients to each other for a "brief intervention" and scheduled follow-up appointment, and joint staffing to discuss best courses of treatment. Integration also can occur without co-location through established protocols for follow-up, regular communication and use of conference calls.

The CICOs will be encouraged to offer supplemental benefits currently not covered or that are limited in existing benefit packages. Offering expanded benefits or additional support services has been shown to influence consumers' choices in voluntary managed care, particularly the availability of those that address critical needs that are often paid out of pocket. The CICOs also will be responsible for coordinating referrals to other existing non-covered services, such as other social and community-based services to support integrated community living.

a. Patient-Centered Medical Home (PCMH)

Although the CICO is responsible for delivery and management of all covered services for this Demonstration including enhance care coordination, care is delivered through the PCMH; therefore, the CICOs must ensure that each consumer chooses (or is enrolled in) a medical home that will provide integrated primary and behavioral health care and will be responsible for providing access to and coordinating comprehensive medical care including routine screenings for physical and behavioral health conditions, prevention and wellness, disease management, acute and specialty care. The medical home, supported by a multidisciplinary team inclusive of waiver case management and health information technology, will coordinate care across the continuum of services based on a consumer's risk level and needs. Through its care coordination function, the PCMH will develop an ongoing relationship with the consumer and engage the family and informal caregiver supports in the multidisciplinary care team functions including care planning, care compliance, and educational opportunities.

b. Care Coordination

Care coordination is at the center of South Carolina's integrated care model. CICOs will be required to ensure care coordination is provided for all consumers. Stakeholders provided significant input into the design of the care coordination model for SCDuE and identified the following key components:

- Comprehensive needs assessment and assignment of each consumer to a risk group, including caregiver assessment for high risk individuals (e.g., Alzheimer's, complex physical and/or medical needs);
- Goal setting and developing and periodically updating the individualized care plan;
- Coordinating primary, acute, specialty, behavioral health, and LTC;
- Assisting the consumer in negotiating the medical care, behavioral health, LTC, and community service system;
- Managing service utilization (including averting hospitalizations, re-admissions, emergency room visits, and nursing facility stays to include the transition from institutions to community setting)⁵;
- Reconciling medications prescribed and adherence to the medication regimen;
- Making regular contact with consumers (amount varies with risk level) for monitoring purposes;
- Making home visits to high risk consumers with a "boots on the ground" approach;
- Scheduling and reminders of appointments;
- Providing consumer/caregiver education including information about treatments, regimens and services;
- Planning for and coordinating transitions between care settings (e.g., discharge planning from hospital to rehabilitation, hospital/rehabilitation to home, or hospital/home to nursing facility);
- Medical and behavioral health support available telephonically 24/7;
- Financial flexibility to furnish needed services; and

⁵ Money Follows The Person (MFP) Grant Program

- Secure, centralized health records accessible to all authorized parties and providers.

c. Multidisciplinary Team

A multidisciplinary team will guide assessment, development of the care plan, and coordination of services to support the PCMH care coordination. The team will be led by a care coordinator with the consumer at the center of the process and will include varying members depending on the consumer's specific needs. Additional team members may include primary care physicians, behavioral health specialists, waiver case managers, MFP transition coordinators, caregivers/informal supports, therapists, community health workers, discharge planners, pharmacists, nutritionists, and other supporting professionals. Depending on the primary needs of the consumer, the behavioral health specialist or waiver case manager may play a more central role in the coordination of services. In smaller and/or rural practices where all disciplines are not required full-time, the CICO will provide needed clinical support through virtual participation of such disciplines as pharmacy, nutrition, assistive technology, etc.

d. Assessment

1. Medical Home

Each consumer will receive a comprehensive physical health exam and behavioral health screening to identify risks, needs for care coordination and services, preferences, and priorities. The assessment will identify chronic conditions; severity levels, gaps in care, and opportunities for reducing avoidable ER visits, inpatient hospitalization, and institutional care. For consumers who are enrolled in a waiver, the medical home will have access to LTC assessment information through the *Phoenix* system. Based on the findings, the consumer and the care team will develop a care plan that addresses the consumer's needs and identifies strategies to meet those needs.

2. Long-Term Care

As functional needs and/or institution to community transition services are identified by the medical home, the care coordinator will coordinate a referral to the State for a level of care assessment and identified services. Under this Demonstration, the State will continue to complete the level of care assessment for LTSS. As the need for LTC assessment is identified, the consumer will receive a screening, and when appropriate, a comprehensive level of care assessment in the home. Consumers will not be subject to waiting lists for services, but will be assessed with prompt service initiation shortly after needs are identified. The waiver case manager will take the lead on coordinating LTC services and supports and ensure that they are integrated into the PCMH care plan. Medical, health, pharmacy, and behavioral health information obtained through the assessment will be incorporated by the care coordinator into the medical record for medical management, other care management and sharing with other providers as appropriate. When there is disagreement between the CICO and waiver case manager on the amount of LTSS, a process will be developed for arbitration/review by the state to ensure timely resolution.

3. Care Plan

The comprehensive care plan will guide the treatment and service delivery for all consumers, particularly those who are identified through the assessment process as having complex care needs that require intensive coordination of services, monitoring, and follow-up. The care plan

will be person-centered and will identify all service needs, planned interventions, and timeframes for completing actions to ensure access to quality care. The care plan will identify consumer and family health issues, behavioral health needs, long-term care needs, and educational needs to promote wellness, chronic condition self-management, independence and information that will help the consumer continue to remain in the community. The care plan will be reviewed at minimum quarterly and updated as significant care needs occur. Also, the waiver case manager will complete a service plan delineating needed LTC services. To ensure CICO oversight and responsibility for all components of care, this plan will be discussed with and formally signed off by the care coordinator. Any issues regarding the services provided or the appropriate levels of those services should be addressed before sign off and as needed when conditions change. Disagreements regarding amount and type of services needed between the CICO and care coordinator will be sent to the state for arbitration/review.

4. Clinical Care Management

Additionally, the PCMH is responsible for providing clinical care management to consumers whose care complexity requires intensive clinical monitoring and follow-up. This may include consumers who have one or more chronic health conditions, both physical and behavioral health conditions, multiple prescription medications, or those who are assessed to be at high risk for emergency department use, hospital admission or nursing facility admission. Clinical care management should address:

- Assessment of clinical risks and needs;
- Medication review and reconciliation with adjustments based on evidenced-based best practices; and
- Enhanced service needs (e.g. coaching, family training and support) for consumer self-management of complex and chronic conditions.

5. Integrated Health Information Technology and Exchange

The current state of health information technology and exchange in South Carolina's primary care practices is both in development and transition. The combination of the movement to meet the requirements of meaningful use as well as the trend for hospitals to purchase community-based medical practices has caused many changes in electronic health records at the practice level. Although many resources (e.g., HITECH, MU incentives) are available, the capacity for fully integrating electronic health records and sharing of health information varies significantly across the state. Stakeholders agree that this is a critical component for fully integrating care across all delivery systems. The State will require the CICO to work with the PCMHs over the course of the Demonstration to develop the capacity to have an electronic health record system that allows the secured sharing of information across providers and between contractors. The CICO must support the PCMH care team in linking with the State's LTC electronic care management systems (*Phoenix* and *Care Call*). See Appendix H and I for details about *Phoenix* and *Care Call*.

e. Covered Services

The SCDuE Demonstration will include a full continuum of Medicare and Medicaid services to consumers that are fully managed, coordinated and authorized through the CICO and its

PCMH.LTSS will be coordinated through the SCDHHS, Bureau of Community Long-Term Care (CLTC). Details of these services are outlined below.

1. Medicare and Medicaid State Plan Services

All Medicare covered services (i.e., Part A – inpatient, hospice, home health; Part B –outpatient; and Part D – pharmacy) and Medicaid state plan services for adults will be included in the capitated payment to the CICO. See Appendix K for a complete list of services.

2. Integrated Behavioral Health Services

CICOs will be required to facilitate integration of behavioral health and primary care practices by developing a broad behavioral health provider network and implementing strategies to support integration (e.g., co-location, formalized communication, data sharing) by including contract language that requires organizations to work collaboratively and provides incentives and education to facilitate that process.

3. Long-Term Supports and Services (LTSS) (Community, Waiver, Nursing Facility Services)

SCDuE will make available all long-term care services currently included in a waiver and nursing facility services to those meeting level of care eligibility. As noted, the waiver services are not part of the capitated rate. A detailed list of these services is provided in Appendix J (Table C.1). The state will continue to assess level of care and determine eligibility for these services. Consumers who are assessed after enrollment and meet the state’s criteria will have access to community-based and nursing facility services as appropriate. The state will also explore with CMS the ability to provide enhanced services (e.g., home delivered meals, homemaker services and adult day care) to consumers based on risk level prior to their meeting nursing facility level of care criteria.

4. Long-Term Care (LTC) Specialist/Waiver Case Manager

A waiver case manager will be an integral member of the multidisciplinary team for consumers requiring LTSS, including those receiving initial community based services prior to reaching waiver level of care eligibility. As described above, although this service is not part of the capitated rate, the State will ensure that the waiver case manager actively participates in the multidisciplinary team and routinely communicates with the care coordinator regarding new information and/or changing service needs.

iii. Additional Supplemental Services

Additional or supplemental services provided through the SCDuE Demonstration encompass those services included in the care coordination model and benefits design described in Sections C.i. and C.ii of this document. These services include PCMH care coordination, multidisciplinary team, comprehensive assessment, behavioral health screening, care plan development, and clinical care management. Administratively, there is a requirement to provide an integrated health information technology/exchange to facilitate care coordination. The CICO will provide an enhanced reimbursement to those larger PCMH providers where enrollment justifies, and/or provide virtual team members in smaller practices, to support multidisciplinary team members to address key individual needs (e.g., behavioral health specialists, pharmacists/academic detailing, nutritionists, and telepsychiatrists).

For those with more complex care needs, in-home respite should be considered to sustain caregivers enabling consumers to remain at home longer. As a recommendation of the ICW, it is essential that advanced directives be a component of the PCMH care coordination activities. Given the population to be served, advanced directives are a critical part of health care planning. CICOs will be required to include advanced directives as an added component.

The rural nature of South Carolina creates many challenges to providing higher cost services statewide. To address deficiencies in specialty and behavioral health practitioner services, SCDHHS has funded varying forms of telehealth, telemonitoring and telepsychiatry. CICOs will be encouraged to utilize these service delivery methods as appropriate.

a. Additional Behavioral Health Services

Behavioral health services traditionally covered by Medicare and Medicaid include acute psychiatric hospitalization, limited outpatient treatment, therapies and counseling, assessment and testing, and psychotropic pharmaceuticals. After a 2½-year process to totally redesign South Carolina's Medicaid State Plan coverage of rehabilitative and behavioral health services, in July 2010, SCDHHS expanded access by enrolling licensed independent practitioners (LIPs) such as social workers, psychologists, nurse practitioners, marriage and family therapists, and counselors. While this effort greatly enhanced the state's capacity to provide integrated behavioral health services, stakeholders indicated serious challenges with provider capacity. The state will examine current policies regarding the enrollment of LIPs to identify barriers to access.

This Demonstration's integration of behavioral health services is consistent with South Carolina movement to more integrated services. In April 2012, behavioral health services, specifically the LIPs providers, were included in the services provided as part of the existing Medicaid MCO's contracts; additionally, addictive disorder services will be carved into these plans effective January 1, 2013. In order to provide truly integrated behavioral health services, stakeholders strongly encouraged consideration of behavioral health services that could not be billed under South Carolina's fee-for-service system. Behavioral health services/providers should be viewed as a "safety net." Those services that treat current, as well as prevent further, behavioral health issues will be considered. The types of services that foster true integration and enhance care include: brief intervention and screening, physician/behavioral health specialists' collaboration, behavioral supports, monitoring adherence to care plan, follow-up, responding to changes, caregiver education, and services/interventions provided in the home (possibly by community health worker or some behavioral health professional or para-professional).

Stakeholders indicated that while telepsychiatry is an important and cost effective means of providing direct services in rural areas, psychiatric consultation with the physician on specific patients also results in building capacity at the local level.

iv. Evidence-Based Practices

CICOs must develop and use processes that ensure the delivery of evidence-based services at the clinical, care coordination, and planning stages of care delivery. This will require the

implementation of decision-support tools and other mechanisms necessary to facilitate seamless service delivery in a coordinated and integrated manner with ongoing support for quality improvement. As an example, the use of academic detailing would greatly enhance the ability of the PCMH to deliver evidence-based service for this population requiring medical and behavioral health interventions. Academic detailing is a non-commercial educational approach aimed at changing prescribing behaviors for specific drugs as well as treatments for specific conditions using evidence-based educational materials and face-to-face meetings with practitioners. The goals are to support patient safety, encourage cost-effective medication choices, and improve overall patient care.

The PCMHs will be expected to incorporate into their practices evidenced-based practices designed to address the following components;

- Supporting the ability of the provider/patient to adequately initiate, monitor, and evaluate a plan of care;
- Emphasis on prevention and avoidable ED, hospital, and nursing facility stays with the goal of improving overall health;
- Consumer self-management education; and
- Process and outcomes driven continuous quality improvement loops.

The CICOs shall incorporate appropriate best-evidence practices driving quality improvement efforts, for example: (i) the US Preventive Services Task Force, the National Committee on Quality Assurance (NCQA), (ii) AHRQ Comparative Effectiveness, Meaningful Use Standards, (iii) CMS Adult Quality measures and (iv) related evidence-based practices on the PCMH. This is an iterative process requiring the CICOs to develop a plan for evaluating and disseminating this information to providers.

v. How the Integrated Care Model Fits with Existing Services

a. Coordination with Existing Medicaid Waivers

As described above, waiver services will be coordinated with other services through the care plan and multidisciplinary team, but will not be included in the capitated rate.

b. Coordination with Existing Managed Care Programs

Two types of managed care plans currently operate in South Carolina: (1) Managed Care Organizations (MCO), the health maintenance organization (HMO) model, and (2) Medical Home Networks (MHN), the Primary Care Case Management (PCCM) model. Currently, there are four MCOs and three MHNs serving the state. MHNs are an option available to all Medicaid recipients, including dual eligibles. South Carolina is exploring the possibility of lifting the MCO restriction preventing dual eligibles from enrolling with MCOs prior to implementation of the program. Therefore, by January 2014, any consumer choosing to opt-out of the Demonstration would be able to enroll in either an MCO or MHN.

South Carolina has no managed behavioral health plans. However, in April 2012, behavioral health services, specifically the LIPs providers, were included in the services provided as part of

the existing Medicaid Managed Care Plans' contracts, and addictive disorder services will be included on January 1, 2013.

c. Coordination with PACE Programs

PACE will continue to be an option for dual eligible consumers who meet the level of care requirements and live in the four counties covered by the two PACE programs. Current PACE consumers are excluded from the Dual Eligible Demonstration program. Procedures will be developed to ensure that in counties where the two PACE programs operate, CICO consumers who reach the level of care requirements for LTSS will be given the choice of PACE and may opt out of the CICO at that time without consideration of enrollment period. The State will develop ways to identify and inform SCDuE consumers that may become eligible for PACE about the program and provide enrollment options. The State realizes that the PACE integrated care model provides valuable services and plans to explore with CMS ways to expand PACE services perhaps in other geographic areas of the state. Any expansion of the PACE program to additional counties will be coordinated with the Demonstration as described above.

d. Coordination with Medicare Advantage (MA) Plans

The SCDuE will coordinate with Medicare Advantage (MA) plans to ensure a smooth transition of individuals between the entities. These plans will continue to exist, serving full dual eligibles that select not to participate in the SCDuE or who opt-out or elect to disenroll.

e. Other State Payment/Delivery Efforts Underway

SCDuE will coordinate with the CCIG payment reform efforts utilizing incentives and withholds.

f. Other CMS Payment/Delivery Initiatives or Demonstrations

South Carolina is currently working with other CMS Innovation Center funded programs. Three Federally Qualified Health Centers (FQHCs) in South Carolina have been funded under the Federally Qualified Health Center (FQHC) Advanced Practice Demonstration. The FQHC Advance Practice Demonstration is a 3-year Demonstration designed to evaluate the effect of the PCMH, in improving care, promoting health, and reducing the cost of care provided to Medicare consumers, including those with dual coverage. Dual eligibles and the PCMH are focus topics that both SCDuE and the FQHC Advance Practice Demonstration address. Both projects aim to reduce the cost of care for dual eligibles and elevate participating South Carolina Medical Homes to a NCQA recognition level. To address these goals, SCDuE will continue to work with the Integrated Care Workgroup (ICW), which has FQHC representation.

SCDuE's work with the Partnership for Prevention and other projects is mentioned in Section F of the Demonstration. SCDuE will collaborate with other funded initiatives, such as the Initiative to Reduce Avoidable Hospitalizations, Health Care Innovation Challenge Initiative, and Comprehensive Primary Care Initiative.

D. Stakeholder Engagement and Consumer Protections

i. Stakeholder Engagement During the Planning and Design Phase

Strategic planning, which included a team of private and public stakeholders and subject matter experts from across the health care services and public policy arenas, was initiated in July 2011.

a. SCDuE(Integrated Care Workgroup (ICW))

In an effort to ensure the successful statewide implementation of this Demonstration with respect to the various federal, state, regional and local considerations, SCDHHS sought to bring together stakeholders who were knowledgeable in all aspects of the Demonstration. SCDHHS, historically, has engaged stakeholders in the development of new programs through advisory committees, workgroups, and public forums. During the development of the grant proposal, SCDHHS engaged members of the Long-Term Care (LTC) Workgroup, facilitated by the SC Public Health Institute, in strategic thinking about the system that would be needed to better serve people who are dually eligible for Medicaid and Medicare.⁶ See Appendix L (Table D.1) and/or the SCDuE web site (<http://msp.scdhhs.gov/scdue/>) for a complete list of the ICW members. This Workgroup, comprised of 20-member organizations representing consumers and advocacy organizations, state agencies and policy makers, and service providers, established the foundation for our current Integrated Care Workgroup (ICW). Once formed, the ICW quickly expanded its membership to include Managed Care Plan representatives, behavioral health experts, physicians, Federally Qualified Health Centers, hospital administrators, discharge planners, nursing facility representatives, and legislative staff.

Since the inception of the ICW, it has served as this Demonstration's advisory committee assisting the SCDuE Project Team with the identification of areas for needed guidance in reconciling any overlap or disconnect in existing plans. To ensure continuity in this Demonstration proposal's implementation process, a specific emphasis was placed on establishing clear and consistent assumptions upon which design and development must be based. This group also assisted in the identification and interpretation of issues where design elements enhanced or detracted from intended outcomes relevant to an integrated delivery system.

In August 2011, SCDHHS, the project team, and members of the ICW began an intensive schedule of planning and design meetings.⁷ SCDHHS ensured that broad stakeholder representation and feedback opportunities were available for all interested parties via in-person meetings and virtual stakeholder engagement. Although ICW members reside across the state, all SCDuE meetings were conducted in compliance with the Freedom of Information Act (FOIA)/Americans with Disabilities Act (ADA) and within the Columbia, SC, metropolitan area, due to its central geographical location within the state. Additionally, SCDHHS provided members with telephone and webinar access for a number of meetings.⁸ In September 2011, ICW members completed an online survey containing questions related to many of the key

⁶ See Minutes from Long-Term Care Workgroup Meeting (2011, March 24). Retrieved from <http://scphi.org/wordpress/wp-content/uploads/2011/05/LTC-Workgroup-Meeting-Minutes-3-24-2011.pdf>

⁷ South Carolina Department of Health and Human Services.(n.d.). On *South Carolina Dual Eligible Demonstration Project's (SCDuE) web site meeting schedule*. Retrieved from <https://msp.scdhhs.gov/scdue/content/meeting-schedule>

⁸ South Carolina Department of Health and Human Services (2012, February 13). *Integrated Care Workgroup – Behavioral Health Focus Group Web Conference (Webinar) On-Demand* [PDF document]. Retrieved from <https://cc.callinfo.com/cc/playback/Playback.do?id=a35pkn>

elements and topics of the October 6, 2012, meeting. Results from this survey helped facilitate this particular meeting.⁹ In addition to the series of broad ICW meetings, the SCDuE team conducted three “design element-specific” stakeholder focus group meetings in the months of January and February 2012.¹⁰ These targeted meetings addressed coordinated care, LTSS, and integrated behavioral health. On March 22, 2012, SCDuE conducted its final ICW planning phase meeting to describe in detail and gain feedback on the care model and other major design elements of the Demonstration. This extended meeting provided ample opportunity for discussion of the design elements and small group focused feedback to guide the final development of the implementation proposal. Stakeholder input from these three small groups can be accessed on the SCDuE web site. Appendix M (Table D.2.) provides a list of specific stakeholder engagement activities.

b. SCDuE Web Site

The SCDuE web site was deployed in September 2011 and serves as one of the primary online resources and communication exchanges for all SCDuE project-related information and activities. The SCDuE web site is publicly accessible, hosted and maintained by SCDHHS (<http://msp.scdhhs.gov/scDuE/>). In addition to the main SCDHHS web site (<http://www2.scdhhs.gov/>), members of the general public and ICW were encouraged to visit the SCDuE web site for frequent updates, announcements, meeting events, and materials. These SCDuE materials include, but are not limited to, presentations, stakeholder input surveys, meeting materials, general information, and results from stakeholder feedback. The draft Demonstration proposal was posted here for the 30-day public comment period.

c. Public Comment

A specific effort was made by SCDHHS to ensure that a broad array of stakeholder comment and feedback opportunities was offered before, during, and after the 30-day public comment period. An invitation was extended to the Catawba Nation, the State’s only federally recognized Native American tribe, to be involved in the stakeholder activities. The Catawba Nation will continue to be encouraged to participate and will be notified of all stakeholder meetings. All ICW Meetings were announced in advance as public meetings; and in January, the ICW meetings were expanded to be public meetings with notices being sent to all who requested it. In addition to general public announcements published on the main SCDHHS web site, stakeholders and the general public were notified about the opportunity to submit comments from a number of internal and external communication channels (i.e., the SCDuE website, ICW email list serve, and other media outlets such as newspapers, consumer advocacy and provider web sites). Importantly, to advance the reach of this opportunity, the SCDuE team requested all ICW members to share this announcement with their collective memberships via web sites, email list serves, and other communication mediums. SCDHHS offers interested persons the opportunity to submit comments by way of mail, email, and a special online web form and/or survey positioned directly on the SCDuE web site. Finally, three public meetings were conducted across the State with a special intent to reach consumers and caregivers for input. These meetings were

⁹South Carolina Department of Health and Human Services. (2011, October 6). *SCDuE Integrated Care Workgroup Meeting #1* [PDF document]. Retrieved from <https://msp.scdhhs.gov/scDuE/sites/default/files/SC%20DuE%20October%206,%202011%20Integrated%20Care%20Workgroup%20Meeting%2001.pdf>

¹⁰South Carolina Department of Health and Human Services.(n.d.). On *South Carolina Dual Eligible Demonstration Project's (SCDuE) web site meeting schedule*. Retrieved from <https://msp.scdhhs.gov/scDuE/content/meeting-schedule>

held on May 7, 2012 in Spartanburg (Upstate), May 9, 2012 in Columbia (Midlands), and May 11, 2012 North Charleston (Lowcountry). On May 15, 2012, a special presentation was also made to SCDHHS's Medical Care Advisory Committee (MCAC).

d. Individual Meetings with Organizations/Associations

Outreach to various constituencies was critical to gaining input and beginning the process of provider education in all areas of this Demonstration design. SCDHHS leadership and staff met with numerous provider associations, provider groups and other organizations to discuss plans for integrated care. Staff attended numerous external meetings with provider and consumer groups to discuss the integrated care proposal design and to answer questions and concerns.

ii. Description of Consumer Protections

Through agreement with CMS and contract provisions with CICOs, SCDuE will ensure that strong protections are in place to ensure consumer's health, safety, and access to high quality health care and supportive services. These protections will include requirements around choice of providers; grievance and appeals processes; and access to supportive customer service assistance. These protections are in addition to the consumer protections around the enrollment process described in Section C.i.c of this document.¹¹

a. Provider Networks

SCDuE requires the CICOs to establish and maintain a network that includes a broad array of providers and assures access to all Medicaid and Medicare benefits. The provider network will include, but is not limited to, behavioral health providers and providers who have experience in serving this population with diverse disabilities. CICOs will be required to enroll providers that are willing to accept and see new patients; with whom a consumer wishes to continue a relationship; who are able to meet the credentialing requirements, license verification, and have not been suspended or terminated from any government program such as, but not limited to, Medicare, Medicaid, and TRICARE. SCDuE will allow a single-case, out-of-network agreement under specified conditions or circumstances in order to ensure continuity of care for the consumer in cases in which a provider does not wish to enroll in the network. SCDuE will also ensure that CICOs demonstrate the capacity to provide, directly or through sub-contracts, the full continuum of Medicare and Medicaid covered benefits, as well as any additional, enhanced services.

b. Continuity of Care and Consumer Choice

Ensuring continuity of care and consumer choice is a major goal of SCDuE. Consumers will have the choice of at least two CICOs in each county. CICOs are required to provide outreach to current providers and continue out-of-network relationships as mentioned in the above Provider Network section. Passive enrollment into a plan that includes a participant's current provider and/or provider network, independent Enrollment Broker assistance, and care coordination through the multidisciplinary team will help ensure continuity of care. Consumers are also

¹¹At minimum, South Carolina will: (i) establish meaningful consumer input processes which may include consumer participation in the development and oversight, (ii) develop, in collaboration with local, State and Federal stakeholders and agency partners, integrated consumer materials that are appropriately designed for varying levels of understanding and comprehension, and cultural language needs; (iii) ensure consumer health information privacy, consumer access, and consumer family/caregiver involvement, (iv) ensure appropriate service access to adequate provider networks, (v) ensure consumers are meaningfully informed about all care options, and (vi) ensure consumer access to grievance and appeals rights under Medicare and/or Medicaid.

guaranteed current prescription coverage for 60-days (90-days for behavioral health medications) after enrollment in the program as another benefit. SCDHHS will provide training for the ADRC network and SHIP counselors to ensure accurate information is available and to assist consumers in understanding the SCDuE program, options available and appropriate referrals.

c. Grievance and Appeal Process

SCDuE proposes to have an integrated Medicaid and Medicare grievance and fair hearing/appeal process that may include having a participant ombudsman type of role. South Carolina will include negotiations with CMS to ensure that consumer protections are included. The specifics of the process are still under discussion and will include the following key elements:

- Timing and notification (to consumers, providers, etc.),
- Criteria for type of appeal (expedited or standard),
- Levels of appeal (internal and external),
- Continuation of services and reimbursement during an appeal, and
- Authorized appeal representatives.

d. Enrollment Assistance

An independent Enrollment Broker will assist the consumers in the selection of/enrollment with providers. In addition to other services, the Enrollment Broker must provide material that is culturally and linguistically appropriate, make services for the deaf and hearing impaired available, operate toll-free services, and ensure that participants are informed of and aware of their rights.

e. Additional Protections

SCDuE will implement other consumer protections that ensure privacy of records; access to culturally and linguistically appropriate care; and the inclusion of caregivers, guardians, and other consumer representatives as appropriate. Consumers will be provided all federal and state rights in this regard. SCDuE will work with CMS to ensure that existing Medicaid and Medicare authorities and protections are required. For example, SCDuE will ensure that consumers incur only the costs associated with Medicare Part D and have advance notice, an upfront option for consumer opt-out, and an opportunity to dis-enroll 90-days after enrollment is effective.

iii. Ongoing Stakeholder Input

The SCDHHS has served as the lead state agency to the CMS/MMCO since the Demonstration's inception in 2011. SCDHHS has been a consistent presence in this innovative effort and has served to foster ongoing stakeholder engagement that will continue throughout implementation of this Demonstration. Numerous approaches will be used to continue to engage stakeholders in the design and implementation of this integrated care program.

The SCDuE web site will continue to serve as one of the primary vehicles for communication and stakeholder engagement. All project related notices and materials will be posted on the website. For example, the web site will contain a link to the State procurement office where all interested parties can access procurement documents (e.g., Requests for Information/Requests for Solutions (RFI/RFS)). The RFI/RFS process will be used to gather additional feedback regarding the integrated care model and specifics to be included in the CICO requirements. The

ICW is fully engaged in this effort. SCDuE will continue to meet regularly with the ICW and/or smaller focus groups at least quarterly around key design features. In an effort to get further consumer input, SCDuE has explored the option of conducting focus groups with advocacy groups including the South Carolina Chapter of the Alzheimer's Association and an adult day care facility.

Additionally, SCDuE will make full use of existing stakeholder groups to provide regular updates and respond to questions and concerns. These groups include SCDHHS' Medicaid Medical Care Advisory Committee (MCAC) and its Coordinated Care Improvement Group (CCIG). See Appendix L (Table D.1) for details about stakeholders. SCDHHS leadership and staff will continue its outreach to both the behavioral health and LTC provider community to continue the education process started during the design phase and to gain better insight into potential barriers.

Finally, consumer satisfaction surveys will be conducted annually as part of the quality improvement measurements.

E. Financing and Payment

As part of the alignment of financial models, the SCDuE proposes to provide blended Medicare and Medicaid payments to CICOs under the capitated alignment model outlined by CMS in the July 8, 2011, State Medicaid Director Letter. South Carolina, through the efforts of the CCIG, is exploring mechanisms that will hold providers accountable for the care they deliver and reward quality of care and improved health outcomes as a function of pay-for-performance linkages to quality metrics and value-based purchasing of health care; this will likely be a complimentary effort to the SCDuE Demonstration.

The State supports a delivery system built on the PCMH model that integrates and coordinates comprehensive services and incorporates evidence-based quality metrics as an ongoing component of evaluation. The SCDuE supports these efforts by building on identified strategies to transform the system of care in South Carolina.

In keeping with overall payment reform goals and strategies to ensure value-based purchasing of health care services, South Carolina will employ the three-way capitated contract, specified by CMS as the mechanism to implement integrated care for non-institutional full dual eligible consumers age 65 and older. South Carolina will work with CMS to ensure that the three-way contract will achieve administrative integration, clear accountability, and shared financial contributions to prospective blended global payments. These are critical components for the success of this Demonstration and the current efforts in South Carolina.

i. Payments to CICOs

Under the three-way capitated contract, the CICOs will receive an actuarially developed, risk-adjusted, blended capitation rate for the continuum of services they provide to SCDuE participants. Medicaid and Medicare will both contribute to the blended rate. Ongoing conversations with CMS will determine the payment mechanism with many of the design aspects still to be finalized with the submission of this implementation proposal. It will require a data-

driven iterative process shaped by the proposed program design and enrollment. The State will work with CMS to explore the establishment of risk corridors to ensure the viability of this Demonstration to protect against underpayment or overpayment to CICOs. Stop-loss arrangements will need to be considered with the potential to cap the dollar amount over the course of the implementation. The availability of data on the implementation will provide needed information to apply a range of options. South Carolina acknowledges this arrangement has implications for shared savings; however, the success of the program requires this be a critical component of the contract negotiations.

South Carolina has taken major steps to ensure an understanding of the data and the drivers shaping the reimbursement model. The analysis of the data will continue through the comment period at the State and CMS levels allowing for a clear understanding of the drivers shaping the payments to the CICOs (see Section B for a detailed approach undertaken to define the target population). Currently, the State is pursuing linked Medicare and Medicaid data for the base period of 2008-2010 to guide the establishment of base capitation rates with risk adjustments to reflect the geographically diverse population of South Carolina.

ii. Incentive for Quality and Savings

Consistent with the work of SCDHHS's CCIG, the use of quality metrics will be an ongoing component of monitoring the short and long-term outcomes of the Demonstration. The State will consider the implementation of a pay-for-performance framework based on meeting or exceeding quality metrics as a withhold amount from the base capitation rate or a performance incentive. CICO bidder proposals are encouraged to include innovative approaches to value-based purchasing of health care services, including deinstitutionalization strategies, internal to the entity with provider shared savings and bundled payments. Furthermore, the State proposes to provide a onetime financial incentive for consumers that are de-institutionalized after a 90-day nursing facility stay and remain in the community with needed support services for at a specified period of time.

F. Expected Outcomes

i. Demonstration Key Metrics

South Carolina has a proven record of identifying, collecting, monitoring, and analyzing data related to quality and cost outcomes in its existing programs, and for ongoing quality improvement initiatives. Since 2007, South Carolina has been working with HEDIS, CAHPS, CMS Adult, survey of nursing homes, and related metrics associated with quality and has been reporting these metrics at the plan, FFS, and statewide levels. In preparation for this implementation of the SCDuE Demonstration, the State has undertaken efforts to examine existing quality, process, and provider measures as the basis to guide the evaluation of this effort. The State will build on this experience and contractual arrangements to support this Demonstration. The final selection of quality and costs measures will be made through a multi-stakeholder process aimed at meeting state and federal requirements. At minimum, the metrics will encompass measures of access, care coordination, patient-centered care, safety, comprehensive care coordination, integration of services, provider satisfaction, cost savings and health outcomes.

The performance of the CICOs will rely on qualitative and quantitative data collection methods, including consumer and provider surveys, consumer focus groups, key informant interviews and claims and encounter data analysis. Measures will be taken at baseline and at various times after implementation of the Demonstration (e.g., every 6-months or every 12-months) depending on the nature of the expected outcome.

The component of quality measurements for the LTSS is already in place. The automated *Phoenix* and *Care Call* systems used to monitor all LTSS provide a rich data source for evaluating consumer experiences, access and utilization of services and assessments and care plans customized to their individual needs and conditions. See Appendix H and I for a more complete description. The State will be able to obtain real-time data on all of these components, including prior approved LTSS. The *Care Call* system monitors service provision of LTSS providers and documents that services have been provided as authorized. It also includes the ability to monitor any exceptions, such as documentation of services from an unauthorized location, provision of services at times of day not specified, missed visits (no service provision on specified days), and numerous other pieces of information about the services. The two systems together also serve to document any corrective actions taken when service provision issues are identified.

The State will be able to compare quality indicators in the Demonstration with comparable data prior to development of this system. The State will also be able to compare outcomes and quality measures for persons in the Demonstration receiving LTSS with a comparison group not in the Demonstration receiving LTSS. In addition to these metrics, South Carolina also has longitudinal data on consumer satisfaction for consumers receiving LTSS. This will provide the baseline for continuing surveys of consumers and allow for comparison with the traditional fee for service system.

Overall, South Carolina expects to achieve three related outcomes through this Demonstration:

- First, there should be a change in the utilization of services. By assessing needs in a coordinated manner, utilization of lower cost preventative services should increase including behavioral health services outpatient and community-based LTSS. This should be accompanied by a reduction of inpatient and institutional services.
- Second, the shift in services should reduce overall costs, allowing the State to share in cost savings and redirect funding to other health care priorities.
- Finally, the coordinated care provided in this Demonstration should result in a positive effect on consumer outcomes. This includes increases in measurable health outcomes as well as an improvement of consumer experiences through providing a system where all components work together seamlessly.

ii. Potential Improvement Targets

A comprehensive list of improvement targets is in development and will be finalized with stakeholder and CMS input. Appendix N (Table F.1) illustrates a number of measurable targets that are under consideration.

iii. Cost Impact

The current non-alignment of Medicaid and Medicare gives states little financial incentive to develop and implement innovative services if the main effect is to reduce hospitalizations, ER visits or readmissions when Medicare is the primary payer for those services. The Demonstration corrects that by allowing cost sharing across the two funding streams. The Demonstration will facilitate innovative approaches allowing for strategies resulting in cost savings and improved health outcomes. As an example, potential cost savings could also occur by allowing services through an assisted living facility as opposed to a nursing facility enhanced by HCBS. In the current system, these are missed opportunities to coordinate care, leverage alternative services, and expand health care options for dual eligible participants. The data user agreement with CMS supported by the initial actuarial work with Milliman© supports the prospects for this proposed model to produce short-term and longer-term savings, offsetting the costs of providing the additional chronic disease management, behavioral health and LTC services.

G. Infrastructure and Implementation

i. Description of State Infrastructure/Capacity to Implement and Oversee the Proposed Demonstration

a. Long-Term Services and Supports (LTSS) Systems

SCDHHS has demonstrated the capacity and infrastructure to design, develop, and implement model programs across the health care spectrum, with particular strengths in long-term support services and managed care programs. Through its Bureau of CLTC, SCDHHS serves participants who meet an institutional level of care with an array of services and supports in their home and/or community. CLTC has shown innovation in its early development of HCBS and has been a leader in the development of an innovative technological infrastructure to support operation of those waivers. South Carolina was one of the early states to pilot an HCBS waiver in the late 70's and expanded that pilot for elderly or disabled participants in 1984. South Carolina was the fourth state to have an approved HIV/AIDS Waiver. An early adopter of the consumer direction philosophy, CLTC added consumer-directed options for the attendant care service (1996) and later companion services in the Elderly/Disabled (E/D) and HIV/AIDS, MR/DD and Head and Spinal Cord Injury Waivers. In 2003, South Carolina was the third state to implement a Choice Waiver and the first state to have a Choice Waiver for the elderly or persons with disabilities. In 2006, the Choice Waiver was expanded to all participants in the Elderly/Disabled Waiver by combining the E/D and SC Choice Waivers into the Community Choices Waiver.

SCDHHS now directly operates or administers nine HCBS (1915c) Waivers. CLTC operates the Community Choices Waiver that serves 12,500 individuals and has a waiting list of 2,500; the HIV/AIDS Waiver serves approximately 1000 persons; and the Ventilator Dependent Waiver serves 35 individuals. Two additional waivers for children include the Medically Complex Children's Waiver that serves up to 200 children; and the Psychiatric Residential Treatment Facility Demonstration Waiver. CLTC oversees four waivers operated by the SC Department of Disabilities and Special Needs: Intellectual Disabilities and Related Disabilities (ID/DD) Waiver, Head and Spinal Cord Injury (HASCI) Waiver, Pervasive Developmental Disorder (PDD) Waiver, and the Community Supports Waiver. Dual eligible participants are enrolled in six of these nine waivers.

Over the last 10 years, SCDHHS has successfully implemented of a series of CMS grants focused on rebalancing LTC including a Nursing Home Transition grant (2001), Real Choice grant (2001), and Money Follows the Person grant (2007). This experience, combined with the state's readiness, speaks to SCDHHS's ability to identify and validate delivery system and payment integration models in order to develop a demonstration model ready for implementation in 2013.

b. Medicaid Managed Care

Although Medicaid managed care has operated in South Carolina since 1996, the state fully implemented managed care by expanding the number of options available in 2005 and implementing the Healthy Connections program in October 2007. Even in a voluntary managed care environment, SCDHHS increased enrollment in managed care from 72,000 in 2005 to 624,720 as of April 1, 2012. On October 1, 2010, SCDHHS moved to a mandatory managed care environment for all consumers except for those in institutional settings, and some people in HCB Waivers.

Two types of managed care plans operate in South Carolina: (1) Managed Care Organizations (MCO), the health maintenance organization model, and (2) Medical Home Networks (MHN), the Primary Care Case Management (PCCM) model. Currently, there are four MCOs and three MHNs serving the state. Since 2002, SCDHHS, via a contract with the University of South Carolina Institute for Families in Society (IFS), has been conducting quality improvement activities for the agency. Annual CAHPS and provider surveys are conducted for the managed care and fee-for-service populations enrolled in the Medicaid program. Approximately 5,000 surveys were completed in 2010 across all segments of the Medicaid population. Additionally, IFS has provided a secure web portal with monthly DCG/HCC clinical classification reports on all enrolled Medicaid recipients with a separate report on behavioral health diagnosis for managed care providers and agency personnel. HEDIS Medicaid measures are calculated for three different periods: Federal Fiscal Year (FFY), State Calendar Year (CY), and State Fiscal Year (FY) for recipients in managed care, FFS, CHIP, and dual eligibles.

South Carolina's Medicaid history with quality improvement efforts is feasible due to a strong capacity to integrate disparate data sources, research partnerships, strong stakeholder involvement and a commitment to improving care while providing cost-effective services. This work has recently been expanded to include access to care metrics associated with social and economic disparities forming the basis for SPA documentation.

c. Integrated Primary Care and Behavioral Health Care

As part of the SPA effective July 1, 2010, SCDHHS greatly expanded coverage by enrolling licensed independent practitioners. The extensive effort enhanced the State's capacity to successfully implement new initiatives to promote integrated behavioral health services and expand access to these services. Effective April 1, 2012, behavioral services are carved into Medicaid managed care plans with plans to carve in addictive disorder services effective January 1, 2013.

d. Data Analytic Capacity

The technical foundation for integrating data is a successful key linker system. South Carolina has been a national leader in the development of innovative solutions to integrate and link disparate data sets. In 1996, South Carolina began “unduplicating” at the person level using all personal identifiers. Each unduplicated person is assigned a random number generated by a computer program algorithm. This number is commonly referred to as the Unique ID or Key Linker. The algorithm uses personal identifiers that include, but are not limited to SSN, first name, middle initial, last name, date of birth, race, and gender. The data is cleaned (i.e., characters are removed from SSN, dates are compared to valid ranges) and standardized (i.e., all characters are converted to uppercase) before being run through the algorithm. In March 2010, the SC DHHS received a \$9.5 million dollar grant from the Department of Health and Human Services to scale SCHIEEx into an operational and sustainable statewide Health Information Exchange (HIE). SCHIEEx currently connects both data consumers and data providers across insurance sources, state agencies, and special programs. The capacity of SCHIEEx provides a rich framework to conduct the required data analysis associated with the dual eligible population in South Carolina. It also supports the capacity of South Carolina to seamlessly link Medicare data with the current integrated Medicaid data system.¹² See Appendix O (Figure G.1) for details. Currently, the State has SCDuE with a new Data Understanding Agreement (DUA) with CMS to expand the analytic capacity of SCHIEEx and to expand the ability to undertake the analysis for this Demonstration.

e. Key Staff

The SC Medicaid program, under the leadership of Director Anthony Keck, will provide the direct and ongoing leadership and involvement of agency staff and programs for the Demonstration. The Demonstration proposal has been developed with the Office of Long Term Care and Behavioral Health. Sam Waldrep, Deputy Director, will oversee the day-to-day management of this Demonstration with staff in the Office’s Bureau of Long Term Care; Community, Facility, and Behavioral Health Services; and Community Options. Roy Smith, Director of Community Long Term Care will oversee systems development and integration of Long-Term Care services into the Demonstration. These Bureaus have experience in managing programs that serve dual eligibles. Additionally the Bureau of Care Coordination will provide support for the Demonstration. Dedicated staff and resources are detailed in Appendix Q (Table I.1).

f. Contractors

SCDHHS has engaged several contractors to assist with the planning, implementation, and data management of SCDuE.

- The South Carolina Office of Research and Statistics will support the integration of *Phoenix* and related software to address seamless care coordination with CICOs systems.
- The University of South Carolina Institute for Families in Society will provide consulting support in the development and implementation of the SCDuE proposal with emphasis on

¹² The State agrees to collect and/or provide data to CMS to inform program management, rate development and evaluation, including but not limited to beneficiary-level data, State plan changes, and supplemental payment data.

monitoring and data analysis to measure short and long-term outcomes. They will serve as the liaisons to the CMS external national evaluators for this Demonstration.

- Milliman© will provide actuarial support to establish SCDuE's rates and work with CMS on the three-way contract.
- The State's existing Enrollment Broker contract will be expanded to include this Demonstration and will provide customer service and consumer enrollment services, including but not limited to, established Medicare and Medicaid policies and protocols.

SCDHHS will continue to rely on external contractors for some specialized services related to the operation of the Medicaid program, including external quality review, metrics development/technical support, Medicaid Management Information System (MMIS) technical support, and pharmacy benefits.

ii. Identification of any Medicaid and/or Medicare Rules That Would Need to be Waived to Implement the Approach

The unique challenges associated with the design and establishment of a new approach to the coordination of a full continuum of Medicare and Medicaid benefits for South Carolina's dual eligibles transcends existing models of care. As part of the planning, design, and development phase of this Demonstration, CMS and SCDHHS will work together to identify areas for needed guidance related to any overlap or disconnect in existing program authorities, with a specific emphasis on establishing clear and consistent requirements upon which implementation of this initiative must be based in order to create operational compliance.¹³ As such, to the extent that variances resulting from South Carolina's proposed Demonstration would have impacted the overall design of a coordinated and integrated care model, not anticipated at and/or before this proposal's 30-day comment period, SCDHHS shall incorporate such changes into the full Demonstration proposal. Furthermore, the State is committed to working with CMS on areas requiring rule changes to successfully implement this Demonstration.

South Carolina currently has a 1915(c) waiver serving an aged/disabled population, Community Choices. Although the State does not believe that additional waiver authority is needed to provide certain demonstration services, South Carolina will continue to work with CMS to determine how to best provide the required and suggested demonstration services.

iii. Description of Plans to Expand to Other Populations and/or Service Areas if the Model is Focused on a Subset of Dual Eligibles or is Less Than Statewide

SC DuE's target population is comprised of full dual eligibles that are not institutionalized and are ages 65 and older. The Demonstration will lay the groundwork for future expansions. It is anticipated that by 2017, the coordinated care infrastructure in South Carolina will be in place permitting expansion beyond the Demonstration target population.

iv. Description of the Overall Implementation Strategy and Anticipated Timeline

See Appendix P (Table G.1) for details about the overall implementation strategy and anticipated timeline.

¹³Mann, C., Bella, M. (2011). *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. (State Medicaid Director Letter# 11-008; ACA# 18). Baltimore, MD: Department of Health & Human Services Centers for Medicare & Medicaid Services.

H. Feasibility and Sustainability

i. Potential Barriers and Challenges for Implementation

A potential challenge to the implementation is the limited experience of the State with capitated systems providing long-term and behavioral health services in South Carolina. New capitated plans, even by companies already having a market share in South Carolina, do not have this history and understanding of the LTSS provider network. To address this challenge South Carolina has taken steps to integrate behavioral health and addictive disorder services into current capitated bundled programs providing a framework for enhancing provider experience with seamless delivery systems. The Medicaid program is exploring ways by which to provide Medicaid dual eligibles the choice of enrolling in a capitated care model with integrated behavioral health services. In preparation for the implementation of this Demonstration, the State is committed to exploring options to address this service delivery gap, including conducting training sessions for selected vendors to ensure that vendors have a full understanding of state-specific issues that will need to be addressed as the plans proceed with serving the dual eligible population.

Rate setting that can provide realized savings based on historical Medicaid and Medicare claims within the demonstration period will pose a challenge. The selection of the Demonstration target population holds the promise of achieving cost sharing and a learning platform from which to expand to other segments of the dual population.

To address these challenges SCDHHS will work closely with CMS, health plans, and stakeholders to find solutions and create opportunities for innovation. This Demonstration project reflects the seamless delivery and innovative value-based purchasing direction of SCDHHS.

ii. Description of any Remaining Statutory and/or Regulatory Changes Needed Within the State in Order to Move Forward with Implementation

At this time, SCDHHS does not anticipate any insurmountable statutory/regulatory changes that would prevent the implementation. SCDHHS is investigating whether the State's nursing home permit day law will require amendment. The issues addressed in the stakeholder groups are viable within the scope of three-way contract arrangement of this demonstration or through a temporary rule process.

iii. New State Funding Commitments or Contracting Processes Necessary Before Full Implementation can Begin

South Carolina anticipates receiving implementation funding related to this proposal to effectively implement the CICO Care Model. This funding will allow the State to enhance the current IT and related infrastructure to successfully implement, monitor, and evaluate this Demonstration.

iv. Scalability/Replication of Proposed Model

The proposed model with a focus on streamlined administrative process, seamless integration, accountability with defined quality outcomes and a commitment to provider-based incentives can be easily replicated statewide and in other states. It provides a new paradigm for rate setting

aligned with our movement towards value-based purchasing and payment reform at the state and federal levels.

I. Additional Documentation

Letters of support are included as Appendix S in the draft submitted to CMS on May 26, 2012.

J. Interaction with Other HHS/CMS Initiatives

i. Partnership for Patients

The two goals of the Partnership for Patients aim to cut hospital readmissions by 20% and reduce by 40% preventable hospital injuries over the next three years. Six healthcare organizations in South Carolina belong to the Carolinas HealthCare System, one of the 26 Hospital Engagement Networks (HEN) that received funding from the Partnership for Patients Initiative. The CICO and plans will work with the HEN healthcare organizations, along with other providers, to continue to address the goals of reducing hospital readmissions and preventable hospital injuries.

Services to be provided through SCDuE would contribute to many of the projected outcomes for Partnership for Patients. For example, care coordination and the multidisciplinary team approach can assist consumers with safe transition between settings of care, to which the U.S Department of Health and Human Services has committed an additional \$500 million dollars, to address. The multidisciplinary team approach and the combined use of the electronic health record with academic detailing can help guide care to address the issue of preventing adverse drug reactions, one of the nine types of medical complications and errors where the potential for dramatic reductions in harm rates has been demonstrated. In addition, care coordination through the multidisciplinary team approach can help manage consumers care to help prevent hospital readmissions.

ii. The Million Hearts Campaign

The Million Hearts Campaign initiative's goal is to prevent one million strokes and heart attacks over the next five years. South Carolina, a CDC funded Heart Disease and Stroke Prevention state, currently has educational and support activities in place to address the issue of heart disease and stroke. Of SCDuE's targeted population, 24.4% has a Medicare diagnostic cardiovascular condition. SCDuE aims to reduce the prevalence of cardiovascular and other chronic diseases through enhanced services, care coordination, and disease management. SCDuE will continue to work with other initiatives to provide education and support in the effort to reduce heart disease and stroke.

SCDuE will continue to collaborate with others to help integrate and support services of the various initiatives that are currently being implemented in the state, including those that address the reduction of Racial and Health Disparities.

Appendices

Appendix A.

The Medicaid Coordinated Care Improvement Group (CCIG)

Appendix B.

Table B.1. Target Population for SCDuE Demonstration, CY2009

Appendix C.

Table B.2. Diagnostic Categorization Based Upon CY 2009 Claims and Enrollment Data – Medicare 5% Sample Files

Appendix D.

Activities for Daily Living Distribution—Dual Age Population

Appendix E.

Table B.4. Service Use Patterns for Non-Institutional Population by Age Group

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Table B.5. Service Use Patterns for Institutional Population by Age Group

Appendix G.

Figure C.1. Example of ICO Organizational and Financial Arrangement

Appendix H.

Phoenix: Community Long-Term Care’s Automated Case Management System

Appendix I.

Care Call: Community Long-Term Care’s Automated Prior Authorization, Service Documentation, Service Monitoring, Billing, and Reporting System

Appendix J.

Table C.1. Waiver Services

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Appendix L.

Table D.1. SCDuE—ICW (Integrated Care Workgroup) Membership

Appendix M.

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Appendix N.

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Appendix O.

Figure G.1. SC Dual Eligible Integrated Project Analytic Data Linkages

Appendix P.

Table G.1. Overall Implementation Strategy and Anticipated Timeline

Appendix Q.

Table I.1. A Detailed Budget

Appendix R.

Glossary and Acronyms

Appendix S.

Letters of Support

Appendix A

The Medicaid Coordinated Care Improvement Group (CCIG)

The purpose of the CCIG is to examine the current Medicaid coordinated care system in South Carolina to determine what is working and what is not working and develop policies that improve health outcomes, cost efficiency, and patient and provider satisfaction. As part of its work, the Group will analyze best practices in Medicaid managed care and Medicaid agencies nationwide for effective application to South Carolina's Medicaid coordinated care system.

This proposal builds on key tenets of the SCDHHS's Medicaid Coordinated Care Improvement Group (CCIG) to frame the approach for this Demonstration. These tenets include the following:

1. Coordinated care efforts should promote health by rewarding the delivery of quality, cost effective and affordable care that is patient-centered and reduces disparities while coordinating services across diverse providers.
2. Effective service delivery models must start by meeting individual patient needs in a holistic and seamless manner in the least intrusive environment.
3. Policies should encourage alignment between differing health care sectors to promote improvement and innovations guided by evidence-based practices.
4. System change must consider the perspectives of consumers, purchasers, payers, physicians, and other health care providers while fostering ways to reduce administrative costs.
5. System change must balance the need for urgency with realistic goals and timelines that take into account the need to change complex systems by achieving sustainable change.

Appendix B.

Table B.1. Target Population for SCDuE Demonstration, CY 2009

CY2009	Total	Individuals Using Institutional Level Services	Individuals Using Long- Term Care Services	Individuals with No Long-Term Care Services	Eligible population Waiver eligible plus non- institutional
Target Population: age 65 and older (% of target population)¹⁴	65,400 (100%)	10,500 (16%) Excluded at time of enrollment	12,000 (18%)	42,900 (66%)	54,900 (84%)

¹⁴ This population includes the numbers of individuals currently enrolled in a Medicare Advantage Plan eligible for enrollment under the proposed demonstration. Using available data from CMS, this numbers is approximately 17,760 or 27% of the target population.

Appendix C.

Table B.2. Diagnostic Categorization Based Upon CY 2009 Claims and Enrollment Data – Medicare 5% Sample Files

CDPS-Medicare Diagnostic	Percent of Scored Recipients	Target Population
<i>Cardiovascular</i>		
Very High	0.4%	(179)
Medium	24%	(1074)
<i>Psychiatric</i>		
High	2.1%	(940)
Medium	3.9%	(1,746)
Medium Low	3.5%	(1,567)
<i>Skeletal</i>		
Medium	11%	(4,925)
<i>Central Nervous System</i>		
High	0.6%	(268)
Medium	2.6%	(1,164)
<i>Pulmonary</i>		
Very High	2.1%	(940)
High	1.1%	(492)
Medium	7.5%	(3,358)
<i>Gastrointestinal</i>		
High	1.8%	(805)
Medium	3.5%	(1,567)
<i>Diabetes</i>		
Type 1 High	0.6%	(268)
Type 1 Medium	10.7%	(4,790)
Type 2 Medium	5.4%	(2,417)
<i>Skin</i>		
High	4.5%	(2,014)
<i>Renal</i>		
Extra High	0.2%	(89)
Very High	15.0%	(6,716)
Medium	0.4%	(179)
<i>Cancer</i>		
Very High	1.5%	(671)
High	2.5%	(1,119)
Medium	1.5%	(850)
<i>Developmental Disability</i>		
Medium	0.2%	(89)
<i>Metabolic</i>		
High	1.0%	(447)
Medium	9.2%	(4,117)
<i>Infectious Disease (AIDS and Other Infectious Diseases)</i>		
High	0.5%	(223)
Medium	2.5%	(1,119)
<i>Hematological</i>		
Extra High	0.1%	(44)
Medium	1.3%	(582)
<i>Recipients</i>		
% Scored	88.7%	92%
Total (scored and unscored)	50,480	44,775

Appendix D¹⁵

Table B.3. Activities for Daily Living (ADLs) Distribution–Dual Age Population

Number of ADLs ¹⁶	Dual Age 65+	
0	40,040	55.0%
1	10,192	14.0%
2	10,920	15.0%
3+	11,648	16.0%
No Answer	-	0.0%
Total	72,800	100.0%

¹⁵ These figures are extrapolated from the Annual Current Population Survey Social and Economic Supplement membership information matched to the 5% sample. As such, it may overestimate the population by not restricting those in nursing facilities. The reader is cautioned to view these numbers as estimates of the distribution breakdown for the target population and not as the actual number of individuals in the demonstration. Annual Social and Economic Supplement to the Current Population Survey (ASES).

¹⁶ An ADL is defined as an affirmative answer to each the following questions from the 2011 Annual Social and Economic Supplement to the Current Population Survey (ASEC).

Is...deaf or does...have serious difficulty hearing?

Is...blind or does...have serious difficulty seeing even when wearing glasses?

Because of a physical, mental, or emotional condition, does...have serious difficulty concentrating, remembering, or making decisions?

Does...have serious difficulty walking or climbing stairs?

Does...have difficulty dressing or bathing?

Because of a physical, mental, or emotional condition, does...have serious difficulty doing errands alone such as visiting a doctor's office or shopping?

Appendix E.

Table B.4. Service Use Patterns for Non-Institutional Population by Age Group

Calendar Year 2009 - 5% Sample Extrapolated to 100%

Non-Institutional Population:	Ages 65-74				Ages 75-84				Ages 85+			
	Member Months: 264,880				Member Months: 213,140				Member Months: 139,260			
Service Category	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM
Medical/Surgical	4,248.6	\$1,452.30	\$514.18	\$467.42	4,572.8	\$1,328.23	\$506.14	\$459.76	3,767.3	\$1,421.54	\$446.28	\$404.98
Nursing Home	3,796.4	399.20	126.30	97.39	8,411.4	386.61	270.99	210.05	9,816.5	390.53	319.47	248.55
Mental Health/ Substance Abuse	186.7	825.11	12.83	11.83	171.2	656.53	9.36	8.46	31.0	916.08	2.37	1.91
<i>Inpatient-Subtotal</i>	8,231.7	952.39	653.31	576.63	13,155.3	717.43	786.50	678.26	13,614.8	677.01	768.12	655.44
Emergency Room	831.8	230.34	15.97	12.06	918.8	217.02	16.62	12.63	663.5	252.70	13.97	10.58
Surgical	437.6	1,092.65	39.85	30.48	362.6	1,163.16	35.14	27.80	210.3	1,312.05	22.99	17.94
Radiology/Pathology/ Lab	2,448.2	216.35	44.14	34.67	2,618.0	148.88	32.48	26.35	2,979.8	114.67	28.47	23.65
Therapy	328.9	661.65	18.13	14.42	538.2	769.53	34.52	27.47	698.0	757.07	44.03	35.07
Other	4,061.0	144.66	48.95	37.73	3,452.4	125.85	36.21	27.74	2,542.0	101.19	21.44	16.28
<i>Outpatient-Subtotal</i>	8,107.5	247.24	167.04	129.36	7,890.0	235.69	154.96	121.99	7,093.5	221.45	130.91	103.52
Surgical	3,305.3	139.46	38.41	30.30	3,534.6	111.58	32.86	25.69	3,277.9	96.66	26.40	20.52
Anesthesia	6,343.4	11.86	6.27	4.91	6,043.4	9.50	4.78	3.75	3,801.8	10.83	3.43	2.71
Office Visits	8,373.9	72.55	50.63	36.54	7,795.4	70.62	45.88	33.16	5,995.7	71.93	35.94	25.81
Hospital Visits	7,881.0	69.66	45.75	35.84	9,987.8	65.44	54.46	42.11	11,374.4	66.99	63.50	47.52
Emergency Room Visits	1,345.5	106.05	11.89	9.16	1,555.0	106.34	13.78	10.76	1,237.4	114.71	11.83	9.24
Immunizations	654.2	14.35	0.78	0.78	656.5	14.50	0.79	0.79	556.7	14.89	0.69	0.67
Hospice	2,376.6	164.11	32.50	32.50	7,459.9	147.49	91.69	91.69	15,794.9	146.71	193.11	193.11

Table B.4. Service Use Patterns for Non-Institutional Population by Age Group

Calendar Year 2009 - 5% Sample Extrapolated to 100%

Non-Institutional Population:	Ages 65-74				Ages 75-84				Ages 85+			
	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM
			Member Months: 264,880				Member Months: 213,140				Member Months: 139,260	
Home Health	3,963.2	194.97	64.39	64.37	5,474.7	193.93	88.47	88.34	5,325.3	293.65	130.31	130.23
Radiology/Pathology/Laboratory	24,717.6	23.75	48.92	41.36	24,630.6	20.57	42.22	35.87	19,913.8	18.79	31.18	6.47
Therapy	1,531.3	22.85	2.92	2.29	497.7	20.81	0.86	0.66	394.7	23.49	0.77	0.62
Mental Health	453.0	56.83	2.15	1.23	212.8	62.48	1.11	0.69	155.1	59.22	0.77	0.46
Other	145,428.0	4.51	54.61	43.13	81,584.7	4.64	31.53	24.74	20,658.3	9.84	16.94	13.18
<i>Professional-Subtotal</i>	206,373.0	20.89	359.22	302.40	149,433.0	32.80	408.45	358.24	88,486.0	69.83	514.88	470.55
Dental	-	0.00	0.00	0.00	3.4	0.00	0.00	0.00	-	0.00	0.00	0.00
Vision	840.8	57.08	4.00	2.78	1,072.0	54.53	4.87	3.43	797.9	59.00	3.92	2.85
Hearing/Speech	57.1	21.20	0.10	0.07	32.7	30.46	0.08	0.06	44.8	31.51	0.12	0.09
Durable Medical Equipment	73,667.2	9.96	61.12	47.65	101,657.1	6.47	54.80	42.81	98,118.1	5.81	47.47	36.96
Ambulance	2,267.0	162.70	30.74	24.38	4,140.4	157.33	54.28	43.09	4,560.1	150.64	57.24	45.30
Other	1,488.7	9.50	1.18	0.91	1,164.3	7.30	0.71	0.54	770.4	3.41	0.22	0.16
<i>Other-Subtotal</i>	78,320.7	14.88	97.14	75.79	108,069.8	12.74	114.75	89.92	104,291.3	12.54	108.97	85.36
	301,032.9	\$50.89	\$1,276.71	1,084.19	278,548.2	\$63.10	\$1,464.66	1,248.42	213,485.6	\$85.60	\$1,522.88	1,314.87

Appendix F.

Table B.5. Service Use Patterns for Institutional Population by Age Group

CY 2009 – 5% Sample Extrapolated to 100%

Institutional Population:	Ages 65–74	Member Months:	14,400	Ages 75–84	Member Months:	32,600	Ages 85+	Member Months:	35,700			
Calendar Year: 2009				Calendar Year: 2009				Calendar Year: 2009				
Service Category	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM
Medical/Surgical	1,600.00	\$1,972.00	\$262.93	\$242.17	3,143.60	\$1,022.16	\$267.77	\$241.20	2,769.70	\$1,603.39	\$370.08	\$333.01
Nursing Home	12,833.30	354	378.59	267.89	13,185.30	353.66	388.59	282.86	14,702.50	365.81	448.19	338.17
Mental Health/ Substance Abuse	566.7	733.77	34.65	31.68	162	676.54	9.13	8.48	-	0	0	0
<i>Inpatient–Subtotal</i>	15,000.00	540.94	676.17	541.74	16,490.80	484.26	665.49	532.54	17,472.30	561.99	818.27	671.19
Emergency Room	666.7	280.38	15.58	12.03	625.8	267.02	13.92	10.8	517.6	266	11.47	8.52
Surgical	216.7	2,531.07	45.7	35.92	184	692.66	10.62	8.19	147.9	1,086.48	13.39	10.26
Radiology/Pathology/Lab	5,533.30	57.78	26.64	23.87	4,012.30	96.66	32.32	26.88	4,349.60	72.87	26.41	22.71
Therapy	1,966.70	933.84	153.05	121.98	1,796.30	853.7	127.79	101.56	1,727.70	722.12	103.97	82.71
Other	2,333.30	74.13	14.41	11.36	1,936.20	92.75	14.97	11.79	1,821.80	91.5	13.89	10.89
<i>Outpatient–Subtotal</i>	10,716.70	285.96	255.38	205.16	8,554.60	280.02	199.62	159.21	8,564.70	236.98	169.14	135.1
Surgical	4,066.70	71.21	24.13	18.85	4,461.30	62.35	23.18	17.64	3,919.30	71.34	23.3	17.96
Anesthesia	5,383.30	5.6	2.51	1.99	2,547.20	6.71	1.42	1.14	2,104.20	14.93	2.62	1.99
Office Visits	1,916.70	79.49	12.7	9.53	2,208.60	86.72	15.96	11.88	1,835.30	79.05	12.09	9.16
Hospital Visits	16,566.70	59.1	81.59	57.98	17,580.40	60.3	88.34	64.86	17,183.20	62.66	89.72	63.75
Emergency Room Visits	1,233.30	107.15	11.01	8.26	1,089.60	126.5	11.49	8.91	995	117.28	9.72	7.58

CY 2009 – 5% Sample Extrapolated to 100%

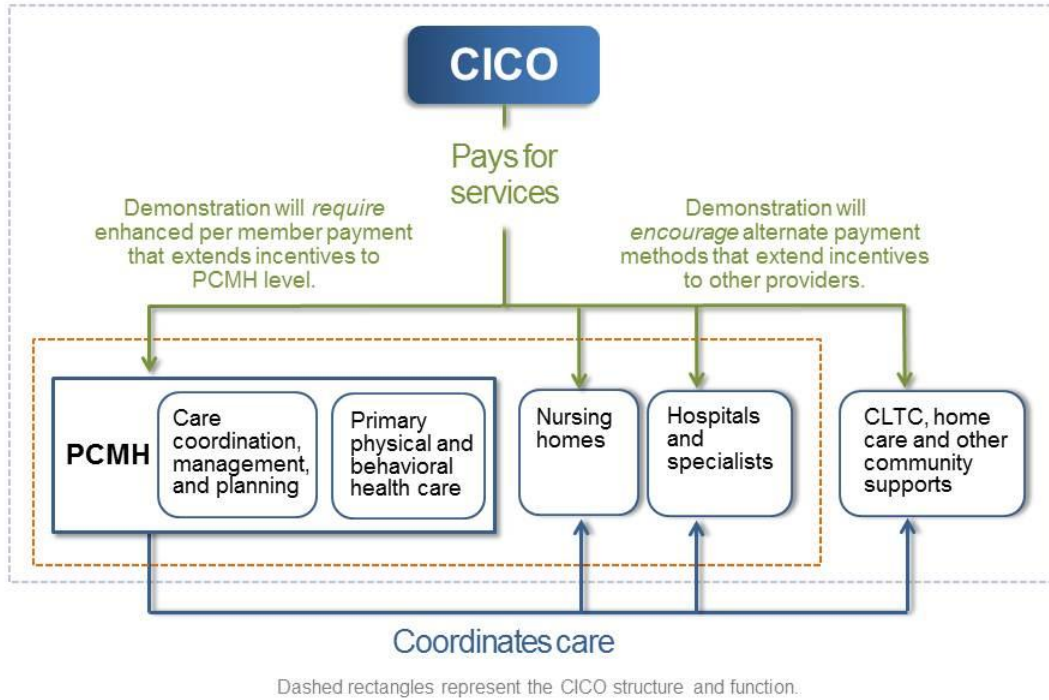
Institutional Population: **Ages 65–74** **Member Months:** 14,400 **Ages 75–84** **Member Months:** 32,600 **Ages 85+** **Member Months:** 35,700

Service Category	Calendar Year: 2009				Calendar Year: 2009				Calendar Year: 2009			
	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM	Utilization per 1000	Cost per Service	Allowed PMPM	Paid PMPM
Immunizations	-	0	0	0	29.4	8.53	0.02	0.02	33.6	14.9	0.04	0.04
Hospice	183.3	205.18	3.13	3.13	1,568.10	152.94	19.99	19.99	1,122.70	213.43	19.97	19.97
Home Health	366.7	195.29	5.97	5.93	265	316.89	7	6.84	114.3	350.87	3.34	3.26
Radiology/Pathology/ Laboratory	25,250.00	15.63	32.89	28.63	27,533.70	17.75	40.73	34.59	23,885.70	16.96	33.75	28.78
Therapy	-	0	0	0	44.2	35.19	0.13	0.1	-	0	0	0
Mental Health	616.7	69.13	3.55	2.25	360.7	59.58	1.79	1.12	349.6	55.53	1.62	0.83
Other	5,933.30	9.66	4.78	3.77	9,268.70	30.5	23.56	18.66	4,779.80	11.54	4.6	3.59
<i>Professional-Subtotal</i>	61,516.70	35.55	182.26	140.32	66,957.10	41.87	233.61	185.75	56,322.70	42.78	200.77	156.91
 												
Vision	1,033.30	48.9	4.21	3.26	861.3	59.38	4.26	3.2	578.2	69.9	3.37	2.6
Hearing/Speech	83.3	30.76	0.21	0.17	22.1	32.49	0.06	0.05	33.6	22.49	0.06	0.05
Durable Medical Equipment	249,683.30	2.06	42.88	33.85	277,303.10	2.08	48.09	38.12	212,389.90	2.14	37.8	29.97
Ambulance	4,700.00	146.84	57.51	45.64	6,773.00	137.8	77.78	61.66	6,299.20	141.46	74.26	58.94
Other	183.3	0	0	0	301.8	0	0	0	235.3	0	0	0
<i>Other-Subtotal</i>	255,683.30	4.92	104.82	82.93	285,261.30	5.48	130.19	103.02	219,536.10	6.31	115.49	91.55
 												
	342,916.70	\$42.64	\$1,218.63	970.14	377,263.80	\$39.09	\$1,228.92	980.51	301,895.80	\$51.82	\$1,303.67	1,054.75

Appendix G.

Figure C.1. Example of ICO Organizational and Financial Arrangement

Example of ICO Organizational and Financial Arrangement



*CLTC refers to home and community-based waiver services (HCBS)

Appendix H.

Phoenix: Community Long-Term Care's Automated Case Management System¹⁷

Medicaid recipients in South Carolina needing long term care services can elect to receive services in their own homes through the Community Long Term Care (CLTC) Programs. Case managers in CLTC coordinate a variety of contracted services such as personal care, adult day health care, home delivered meals, and other Medicaid services designed to keep the consumer at home rather than in a nursing facility. Over 12,000 elderly or disabled South Carolinians receive these home care services.

Since 1991, case managers and nurses have been able to use an automated case management system to assist them in their work. This system keeps automated records of a number of critical functions, including all intake, assessment, and care planning activities.

The most recent version of this software, implemented in 2010, is called *Phoenix*. *Phoenix* is designed to be used with tablets so case managers and nurses can obtain electronic signatures and work toward a completely paperless system. The tablets download critical data and upload it to the web as needed. Data input can be done through the tablets or directly to the web.

There are a number of features of available for workers. These include a dashboard showing all assigned cases, activities due and performed, and notifications. There is a database of medications allowing them to indicate current and former medications being taken by participants. There is also an automated way to identify need for home repairs and electronically send them to a specialist who will due a home assessment and provide specifications for providers.

Providers can also access parts of *Phoenix*. They receive e-mails indicating when case managers have made a referral or authorization for services to their company. They can electronically accept these referrals and view pertinent information related to the services they provide, such as the service plan and demographic information.

Additional features of *Phoenix* include a section for home assessment, one for caregiver supports, one measuring quality indicators and reporting out by individual worker and CLTC office for a number of measures and a feature that pulls data from various source in *Phoenix* to ensure the service plan reflects all identified needs and goals. There are also edits to ensure compliance with federal regulations (e.g., waiver admission is within 30-days of the most recent level of care determination) as well as state policies. There is also a means to identify waiver participants most at risk for missed in-home visits and those most at risk in the event of natural disasters.

¹⁷ An earlier version of this software has been featured by CMS as a Promising Practice in Long Term Care (<http://www.cms.hhs.gov/PromisingPractices/HCBSPPR/list.asp?datefiltertype=-1&datefilterinterval=-&datafiltertypename=Report+Category&datafiltertype=3&datafiltervalue=-&filtertype=keyword&keyword=south+carolina&cmdFilterList=Refresh+List>).

Appendix I.

Care Call: Community Long-Term Care's Automated Prior Authorization, Service Documentation, Service Monitoring, Billing, and Reporting System

The *Care Call* system is an automated system used by four of South Carolina's approved Medicaid waiver programs (Community Choices, HIV/AIDS, Medically Complex Children and Mechanical Ventilation) for prior authorization of services, service documentation, service monitoring, web-based reporting, and billing to MMIS. It is also used for the children's nursing and personal care services. These waivers and services have a total of approximately 14,400 recipients on any given day.

For documentation of personal care services provided in a participant's home, workers call a toll free number upon commencing and ending services. For other in home services and services not provided in a participant's home, providers call a toll free number to document service delivery or document service delivery on the Internet. In all cases, services documented are compared with the prior authorization to determine if the service was provided appropriately. By comparing the call with the prior authorization, only providers with authorizations can bill for services. By having two calls made for personal care services provided in a participant's home, the length of the call ensures that providers only receive payments for time served to the participant.

Since its inception, the *Care Call* system has identified that many providers had been billing for more time than actually delivered. This resulted in cost savings for the CLTC program. Also, since the system monitors the phone being used to make calls, a number of cases were identified where workers made calls from their own homes or some other inappropriate location. Several referrals to the Attorney General's Office have resulted in convictions based upon *Care Call* data.

For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services. If a provider notices a participant is not receiving service as authorized, the provider can implement the backup plan that is in place for the participant. Personal care providers also use *Care Call* information to complete payroll.

Providers were initially reluctant to use the system. However, since the implementation of *Care Call*, they have come to understand the benefits to them in monitoring, billing and payroll.

Participants enrolled in a waiver who receive self-directed care utilize a financial management component to pay employees. This component of the system was added in 2003. On a bi-weekly basis, *Care Call* generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

Appendix J.

Table C.1. Waiver Services

Waiver	Community Choices		HIV/AIDS		Mechanical Ventilator	
Population Served	Aged & Disabled 18+ years of age		Diagnosed with HIV/AIDS Any age		Requires Mechanical Ventilator 21+ years of age	
Point-of-Entry	CLTC Area Office		CLTC Area Office		CLTC Area Office	
Level-of-Care	Nursing Facility		At-Risk for Hospitalization		Nursing Facility	
Services	Case Management Personal Care I & II Attendant Care Companion Environmental Modifications Home Delivered Meals Adult Day Health Care* Institutional and CRCF Respite Care Personal Emergency	Response System (PERS) Incontinence Supplies Nursing Home Transition Services Chore Service Nutritional Supplements Limited Durable Medical Equipment Telemonitoring	Response Case Management Personal Care I & II Attendant Care Companion Environmental Modifications Home Delivered Meals	Nutritional Supplements Private Duty Nursing Additional Prescription Drugs Incontinence Supplies	Personal Care I & II Attendant Care Private Duty Nursing Environmental Modifications Specialized Medical Equipment & Supplies	Institutional and In- Home Respite Care Personal Emergency Response System (PERS) Prescription Drugs Incontinence Supplies Nutritional Supplements

Appendix J.

Table C.1. Waiver Services *continued*

Waiver	Intellectual Related Disabilities		Head & Spinal Cord Injuries		Community Supports	
Population Served	All ages with Intellectual Related Disabilities		Birth to 65 years of age with Head or Spinal Cord injuries or Similar Disabilities		All ages with Intellectual Related Disabilities	
Point-of-Entry	DDSN Single Point of Entry 1-800-289-7012		HASCI Information and Referral 1-866-867-3864		DDSN Single Point of Entry 1-800-289-7012	
Level-of-Care	ICF/MR		Nursing Facility or ICF/MR		ICF/MR	
Services	Personal Care I & II Residential Habilitation Environmental Modifications Private Vehicle Modifications DME/Assistive Technology Additional Prescription Drugs Respite Care Audiology Services Adult Companion Services Psychological Services Nursing Services Adult Dental	Adult Vision Adult Day Health Care (ADHC) ADHC-Nursing ADHC-Transportation Behavior Support Services Adult Attendant Care Career Preparation Employment Services Day Activity Services Community Services Support Center Services Personal Emergency Response System	Prevocational Habilitation Day Habilitation Supported Employment Attendant Care Health Education for Consumer Directed Care Peer Guidance for Consumer Directed Care Residential Habilitation Medical supplies, equipment and Assistive Technology Additional Prescription Drugs	Respite Care Speech, Hearing and Language services Personal Emergency Response System Physical Therapy Occupational Therapy Psychological Services Behavior Support Services Nursing Services Private Vehicle Modifications Environmental Modifications	Personal Care I & II Adult Day Health Care (ADHC) ADHC-Nursing ADHC-Transportation Respite Care Environmental Modifications Specialized medical equipment, supplies, assistive technology and appliances	Psychological Services Private Vehicle Modifications Behavior Support Services Day Activity Services Career Preparation Community Services Employment Services Support Center Services In-home Support

Appendix K.

Table C.5. South Carolina Proposed Benefits Design for Duals Demonstration

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Inpatient Hospital	x				x
Skilled Nursing Facilities	x	x			x
Nursing Facility Services (Skilled, intermediate, level of care)		x			
Hospice	x	x			x
Home Health	x	x			x
Physician Services	x				x
Outpatient Hospital	x				x
Labs	x				x
X-Rays	x				x
Physical Therapy	x				x
Speech Therapy	x				
Occupational Therapy	x				x
DME	x	x			x

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Pharmacy	x				x
Rural Health Clinic Services		x			x
FQHC Services		x*			x
Ambulance Transportation		x			x
Medical Transportation		x			x
Podiatry		x			x
Family Support Services		x			x
Rehabilitative Therapy		x			x
Behavioral Health Screening		x*			x
Crisis Management		x*			x
Community Support Program (Rehabilitative Psych. Services and Peer Support Services)		x*			x
Diagnostic Assessment Services		x*			x
Medication Management		x*			x
Partial Hospitalization		x*			x
Psychological Testing/Evaluation		x*			x
Service Plan Development		x*			x

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Substance Abuse Examination		x*			x
Therapies (Individual, Family, and Group)		x*			x
Telepsychiatry		x*			x
Brief Intervention				x	x
Home and Community-Based Services (HCBS)			x		x
Adult Day Care			x		x
Adult Foster Care Services			x		x
Case Management			x		x
Day Habilitation Services			x		x
Personal Care I and II			x		x
Private Duty Nursing Services			x		x
Attendant Care			x		x
Companion			x		x
Environmental Modifications and Enhanced Environmental Mods			x		x
Home Delivered Meals			x		x
Transportation			x		x

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Respite in an institution or CRCF			X		X
Personal Emergency Response System (PERS)			X		X
Incontinence Supplies			X		X
Nursing Home Transition Services			X		X
Nutritional Supplements			X		X
Tele-Monitoring			X		X
Bath Safety Supplies			X		X
Comprehensive Needs Assessment and Goal Setting				X	X
Care Planning/Management/Coordination (including home visits)				X	X
Monitoring adherence to care plan, follow-up, responding to changes				X	X
Follow-up, coordination across specialists/providers				X	X
Caregiver Education				X	X
Transition Services				X	X
Multidisciplinary Team (physical and virtual)				X	X
Assistive Technology				X	X
Routine Dental Services				X	X

Benefits	Medicare	Medicaid	HCBS Waiver	Proposed Additional Services	Duals
Routine Vision Services				x	x
Non-Covered Prescriptions				x	x
Behavior Supports				x	x
Assisted Living				x	x
Supportive Housing				x	x
In-Home Respite Care				x	x
Enhanced Adult Day Services				x	x
Telemedicine				x	x
*x = Behavioral Health Services provided under Medicaid					

Appendix L.

SCDuE—ICW (Integrated Care Workgroup) Membership

SCDuE-ICW Member	Organization
Paul Accardi Chief Operating Officer	Absolute Total Care
Valerie M. Aiken	CarePro Health Services
Teresa Arnold Associate State Director - Advocacy	AARP, South Carolina
John Barber Executive VP & CFO	White Oak Manor, Inc.
Judith (“Judy”) Baskins Administrative Director	Palmetto Health Palmetto SeniorCare
Coretta D. Bedsole	Palmetto Public Affairs, LLC
Susan Bowling Managing Consultant	Kerr & Company, Inc.
John C. Belissary SCAPCP	New Generations Home Care, Inc.
Thomas Brown President and CEO	Lutheran Homes of South Carolina
Douglas E. Bryant President	The Bryant Company
Kendall Buchanan Director, Government Relations	Richardson & Ritchie
Don Clair Vice President, Medical Strategy	Magellan Health Services
Bobbie Crimm Vice President	Absolute Total Care
Anna Maria Darwin	Protection and Advocacy for People with Disabilities, Inc.
Timothy (“Tim”) Davis CEO	Advanced Care Management, LLC
Grace Dotson Director, Hospital Case Management	Greenville Hospital System (GHS)
Donnie Edwards Vice President, General Manager	Wellpath / Coventry Health Care, Inc.
Barbara Freeman, MD President & Chief Medical Officer	SC Solutions

SCDuE-ICW Member	Organization
Kathryn D. Gailey Executive Director, Government Programs	SC Solutions
Daniel Gallagher President	UnitedHealthcare
Lorri Gibbons VP, Quality Improvement & Patient Safety	South Carolina Hospital Association (SCHA)
Scott Graves Vice President, Medicaid Managed Care	BlueChoice HealthPlan
Betsy Hall Strategic Liaison, President's Office	Absolute Total Care
Gerald Harmon, MD	Palmetto Physician Connections
Timothy ("Tim") Hartnett Care Mgmt. and Medical Support Services	SC Dept. of Health & Human Services (SCDHHS)
Cindy Helling Executive Director	Select Health of South Carolina, Inc.
Bob Hunter LTC Advocacy Volunteer	National MS Society, Mid-Atlantic Chapter
Heather Jones Director, Quality Initiative & State Liaison	SC Home Care & Hospice Association
Courtney N. Jones Compliance & Regulatory Affairs	Palmetto Physician Connections
Anthony E. Keck Director	SC Dept. of Health & Human Services
Robert "Robby" Kerr President	Kerr & Company, Inc.
Lea B. Kerrison Executive Director,	Kerrison Law, LLC Medicaid Health Plans of SC
Ken Kinard Public & Government Affairs	Tompkins & Kinard, LLC
Bryan Kost Senior Consultant	SC Dept. of Health & Human Services
Kathi K. Lacy Associate State Director, Policy	SC Dept. of Disabilities & Special Needs
LigiaLatiff-Bolet	SC Dept. of Mental Health (SC DMH)
Jean LeMasurier Senior Vice President for Public Policy	Gorman Health Group, LLC
Ana Lopez-De Fede Research Professor	University of South Carolina (USC)
Linda Malone Executive Assistant	Kerr and Company

SCDuE-ICW Member	Organization
Cesar D. Martinez President and CEO	Palmetto Physician Connections
Melanie Matney Executive Director, Access Health	South Carolina Hospital Association (SCHA)
Kathy Mayfield-Smith Research Associate Professor	University of South Carolina (USC)
Nancy A. McCartney	Windsor Health Group, Inc. Sterling Health Plans
Scott Middleton Founder & CEO	Agape Senior
Sheila L. Mills Program Manager	SC Dept. of Mental Health (SCDMH)
Vickie Moody President	Aging Services of South Carolina
Stephen Moore	Absolute Total Care
Wendy Moore SC Regional Director	Active Day
Linda Motley Program Director, Attendant Care	SC Dept. of Health & Human Services (SCDHHS)
John Muraca	Southern Health Services, Inc., Wellpath Select
James "Matt" Orr Associate Professor	USC School of Medicine (USCSOM)
Bonnie C. Pate Executive Director	South Carolina SHARE
Nathaniel J. Patterson Project Director	SC Dept. of Health & Human Services (SCDHHS)
Joseph Lee Pearson Director of Operations	SC Inst. of Medicine and Public Health (IMPH)
Pamela M. Perry Vice President, Government Relations	Amerigroup Corporation
Bill Prince	Nelson Mullins
Carol B. Reed Research Associate	University of South Carolina (USC)
Vicky Reynders Indian Health Services Representative	Catawba Services
Denise Rivers Deputy Director	Lt. Governor's Office on Aging
Judi Ryder Executive Director	Carolina Medical Homes, LLC

SCDuE-ICW Member	Organization
Roy Smith Director, Community Long Term Care	SC Dept. of Health & Human Services (SC DHHS)
Erica M. Studer Program Coordinator	University of South Carolina
Beth Sulkowski Director, Communications and Advocacy	Alzheimer's Association, South Carolina Chapter
Donna Thompson Medicaid/Medicare Liaison	SC Primary Health Care Association (SCPHCA)
Bob Toomey Director	Dept. of Alcohol & Other Drug Abuse Services
Sam Waldrep Deputy Director, LTC & Behavioral Health	SC Dept. of Health & Human Services (SCDHHS)
Sam Wiley Vice President of Programs	Alzheimer's Association – SC Chapter
Kim Wilkerson Director, Regulatory Affairs	South Carolina Health Care Association (SCHCA)
Gwen Williams Business Development Executive	Molina Medicaid Solutions
Philip Willis	Palmetto Public Affairs
Lathran Woodard Chief Executive Officer	SC Primary Health Care Association (SCPHCA)
Sandy Wright	BlueChoiceHealthPlan Medicaid Blue Cross Blue Shield

Appendix M.

Table D.2. Stakeholder Engagement Activities

Dates	Description
January 27, 2011	LTC Workgroup Meeting
March 24, 2011	LTC Workgroup Meeting
May 26, 2011	SCDuE LTC Workgroup/ICW Meeting
July 25-27, 2011	Meeting of Key State Stakeholders around Integrated Primary and Behavioral Health Care at the SAMHSA Conference
August 1, 2011	LTC Workgroup Meeting
August 2, 2011	State Agency Meeting
August 18, 2011	SCDuE-ICW
September 13, 2011	SCDuE Website – Deployed
September 26, 2011	LTC Workgroup Meeting
September 30, 2011	SCDuE Project Survey
October 5, 2011	CMS/MMCO Site Visit in South Carolina
October 6, 2011	SCDuE-ICW with CMS/MMCO Project Officer site visit
October 12, 2011	Hospitals/Nursing Home Meeting - presentation
October 24, 2011	Financial Model Sub-Committee Meeting
October 25, 2011	LTC Workgroup Meeting
December 5, 2011	LTC Workgroup Meeting
December 14, 2011	Medicaid CCIG Meeting - presentation
January 24, 2012	SCDuE-ICW and Public Meeting with CMS/MMCO staff present

Dates	Description
February 2, 2012	SCDuE-ICW and Public Meeting
February 6, 2012	SCDuE LTC Sub-Committee meeting
February 7, 2012	Medicaid CCIG Meeting - Presentation
February 13, 2012	SCDuE Behavioral Health Sub-Committee
March 22, 2012	SCDuE-ICW and Public Meeting
April 16, 2012	Posted Draft Proposal to the SCDuE website for 30-day public comment
May 7, 2012	Consumer Meeting for Comments on the Proposal (Spartanburg)
May 9, 2012	Consumer Meeting for Comments on the Proposal (Columbia)
May 11, 2012	Consumer Meeting for Comments on the Proposal (Charleston)
May 15, 2012	Medical Care Advisory Committee Meeting

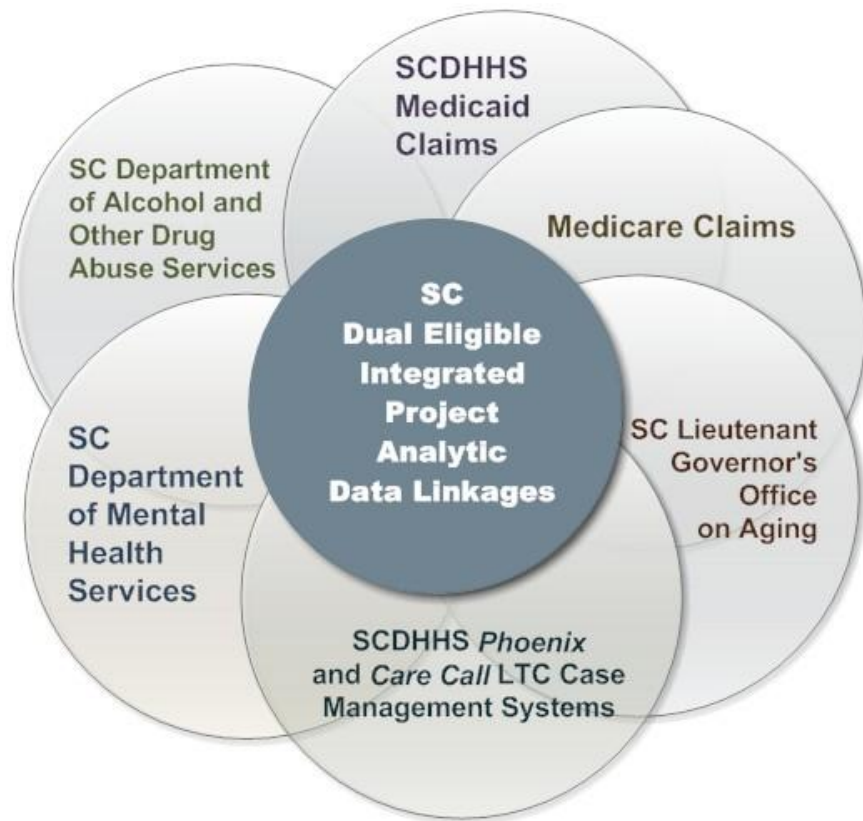
Appendix N.

Table F.1. List of Potential Improvement Targets

<p>Primary Care</p> <ul style="list-style-type: none"> - % of consumers screened, referred for behavioral health care who receive concurrent medical management to avoid adverse events - % of consumers who receive recommended treatment and follow-up related to identified chronic conditions - % of participating practices who achieve Level 1 (or higher) PCMH certification
<p>Behavioral Health Services:</p> <ul style="list-style-type: none"> - Percent <u>increase</u> in the utilization of behavioral health services - Percent <u>decrease</u> in inpatient admissions due to behavioral health diagnoses - Improvement in medication management - Follow-up after hospitalization for mental illness - Initiation and engagement of alcohol and other drug dependent treatment
<p>Long-Term Care:</p> <ul style="list-style-type: none"> - Number of consumers referred to home- and community-based waivers by the CICOs - Length of time from referral to waiver admission - Percent increase in the 65+ population in waiver programs - Percent decrease in nursing facility admissions - For those entering nursing facilities, percent increase in time from waiver enrollment to nursing facility admission - Number of critical incidents reported by the waiver case manager to the CICO.
<p>Integrated Primary Care:</p> <ul style="list-style-type: none"> - Percent reduction in avoidable hospitalizations - Percent reduction in 30-60 day readmissions - Percent reduction in avoidable emergency department visits - Percent reduction in unnecessary prescription medications - Use of high-risk medications in the elderly - Potentially harmful drug-disease interactions in the elderly - Annual monitoring for patients on persistent medications - Persistence of a beta-blocker treatment after a heart attack
<p>Overall:</p> <ul style="list-style-type: none"> - Percent of consumers who do not opt out of CICO plans - Consumer experience survey results, including measures of transparency across care categories - Percent of consumer and providers who indicate satisfaction with the integrated service demonstration - Percent of providers who do not opt out of the CICOs network

Appendix O.

Figure G.1. SC Dual Eligible Integrated Project Analytic Data Linkages



Appendix P

Table G.1. Overall Implementation Strategy and Anticipated Timeline

Timeframe	Key Activities/Milestones
April 16, 2012	Post for Public Comment
April 16 – May 16, 2012	Public Comment Process and Ongoing Stakeholder feedback
May 16, 2012	Deadline for Public Feedback
May 17 – May 25, 2012	Incorporate public comments and revise proposal as needed
May 26, 2012	Final Submission to CMS
May 31 – June 30, 2012	CMS posts for public comment, CMS/State review public comments and incorporate as appropriate
June 15, 2012*	State submits draft documents for Medicaid authority
June – September 2012	State infrastructure modifications and provider outreach regarding program changes
June – December 2012	Continued stakeholder engagement
June and July 2012*	Develop and Issue Request for Information
July 9 – September 9, 2012	MOU development/finalization
September 12, 2012	MOU signed by CMS and State
September 14 – 26, 2012	State/CMS develop RFP for plan selection
October 29, 2012	Release RFP
November 2012	Plans Notice of Intent to Apply (NOIA) Due for 2014 contract year
January – December 2013	Continued stakeholder engagement
Mid-February 2013	CMS 2014 Draft Call Letter provides additional information for plans
February 15 – June 15, 2013	State/CMS plan RFP submission review and negotiations

Timeframe	Key Activities/Milestones
Late February 2013*	CMS plan demonstration applications are due
Mid-April 2013*	Interested plans submit Part D formularies
May 2013*	Interested plans submit Medication Therapy Management Program
By June 15, 2013*	Interested plans submit proposed plan benefit packages
June 18 – September 18, 2013	Three-way contract documents finalized
July 30, 2013	Final Plan Selection completed
August 1 – September 20, 2013	Readiness reviews
August 15 – September 30, 2013	Plans finalize policies, procedures
September 20, 2013	Three-way contracts signed
October 1, 2013	Consumer notification (Region-1)
October 1 – December 7, 2013	Open enrollment (Phase I, Region-1)
October 1, 2013	Opt-out consumers enrolled in alternative options
January 1, 2014	Demonstration Start / Services Begin (Phase I, Region-1)
April 1, 2014	Consumer notification (Region-2)
April 1 – June 30, 2014	Open enrollment (Phase II, Region-2)
July 1, 2014	Demonstration Start / Services Begin (Phase II, Region-2) completing statewide implementation

Appendix Q

Glossary and Acronyms

Activities for Daily Living (ADL)

An ADL is defined as an affirmative answer to each the following questions from the 2011 Annual Social and Economic Supplement (ASES) to the Current Population Survey (CPS):

- Is... deaf or does...have serious difficulty hearing?
- Is...blind or does...have serious difficulty seeing even when wearing glasses?
- Because of a physical, mental, or emotional condition, does...have serious difficulty concentrating, remembering, or making decisions?
- Does...have serious difficulty walking or climbing stairs?
- Does...have difficulty dressing or bathing?
- Because of a physical, mental, or emotional condition, does...have serious difficulty doing errands alone such as visiting a doctor's office or shopping?

A higher number of ADLs may indicate the level of assistance that an individual may need.

Aging and Disability Resource Centers (ADRC)

Provide a single coordinated system of information and access for seniors, caregivers and adults with disabilities seeking long-term care by minimizing confusion, enhanced individual choice, and supporting informed decision-making. ADRCs make it easier for consumers to learn about and access existing services and supports that are available in their communities.

AHRQ

Agency for Healthcare Research and Quality

Annual Social and Economic Supplement

A supplement to the national Current Population Survey (CPS), sponsored by the Bureau of Labor Statistics, Census Bureau, and the Department of Health and Human Services. Information from the ASES is used to produce annual income and migration statistics, including poverty figures. It is also used to produce work experience, noncash benefits and health insurance data.

Behavioral Health Services

Behavioral health services include an array of medical or remedial services that have been recommended by a physician or other Licensed Practitioner of the Healing Arts or as further determined by the SCDHHS for maximum reduction of physical or mental disability and restoration of a consumer to his/her best possible functional level.

Capitation

A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan consumer's health care services for a certain length of time.

Care Coordination

Care Coordination assists individuals/consumers in gaining access to needed Medicaid, Medicare, and other services, as well as social, educational, and other support services, regardless of the funding source for the services.

Care Call

The Care Call system is an automated system used for service documentation, service monitoring, web-based reporting, and billing to MMIS. For documentation of personal care services provided in a participant's home, workers call a toll free number upon starting and ending services. For other in home services and services not provided in a participant's home, providers call a toll free number to document service delivery or document service delivery on the Internet. In all cases, services documented are compared with the prior authorization to determine if the service was provided appropriately. For monitoring of service delivery and reporting, real time reports allow providers and case managers to monitor participants more closely to ensure receipt of services. On a weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing.

Center for Health Care Strategies (CHCS)

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

Centers for Medicare & Medicaid Innovation

Congress created the Center for Medicare and Medicaid Innovation, known as the "Innovation Center," as part of the Centers for Medicare & Medicaid Services (CMS). The Innovation Center's mission is to help transform the Medicare, Medicaid and CHIP programs to deliver better health, better healthcare and reduced costs through improvement for CMS consumers. By doing so, it will help to transform the health care system for all Americans.

Centers for Medicare & Medicaid Services (CMS)

The Health and Human Service agency responsible for Medicare and parts of Medicaid

Chronic Illness and Disability Payment System (CDPS)

A diagnostic classification system originally used to make health-based capitated payments for certain Medicaid populations that were revised for use in adjusting capitated Medicare payments to health plans. South Carolina utilized the system to predict disease occurrence in certain regions of the state.

Community Choices HCBS Waiver

A waiver authorized pursuant to section 1915(c) of the Social Security Act that permits a state to furnish an array of home- and community-based services that assist Medicaid consumers to live in the community and avoid institutionalization. South Carolina waiver services include but are not limited to personal care, attendant care, companion, and environmental modification, home delivered meals, Adult Day Health Care (ADHC), respite care, Personal Emergency Response System, and incontinence supplies.

Community Long Term Care (CLTC)

Community Long Term (CLTC) operates home- and community-based waiver programs for persons eligible for nursing home care but who prefer to receive their services in the community. Through a process of case management and an individualized service package, waiver clients are able to successfully remain at home at a cost to Medicaid that is substantially less than the cost of institutional care. The CLTC program began statewide in 1983 after a three-year pilot program in the Upstate. It was first established to meet the needs of the elderly or disabled person who was not able to care for himself or herself independently over a long period of time, perhaps for life. Currently, CLTC administers and operates three Medicaid waiver programs: Community Choices waiver, HIV/AIDS Waiver and Ventilator Dependent Waiver.

Community Support Services

Services that promote disease management, wellness, and independent living and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Coordinated Care Improvement Group (CCIG)

A group of concerned stakeholders advise SCDHHS. The major duty of the CCIG is to examine the current Medicaid coordinated care system to determine what is working and not working; develop policies that improve health outcomes, cost efficiency, and patient and provider satisfaction, and analyze best practices in Medicaid managed care and Medicaid agencies nationwide.

Coordinated and Integrated Care Organization (CICO)

Organizations such as managed care organizations and care coordination service organizations that can bear risk and contract with a variety of providers in order to provide or arrange for a full continuum of services including primary and behavioral health care, specialists, hospital, and LTSS.

Current Population Survey (CPS)

The primary source of labor force statistics for the U.S. is sponsored by the US Census Bureau and the US Bureau of Labor Statistics, and is the source of various economic statistics, including the national unemployment rate. The CPS provides data on issues related to earnings and employment.

Data Use Agreement (DUA)

Legal binding agreement which CMS requires to obtain identifiable data. It also delineates the confidentiality requirements of the Privacy Act of 1974 security safeguards and CMS's data use policy and procedures.

<http://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English>

Disenrollment

Ending health care coverage with a health plan.

Dual Eligibles

Individuals entitled to Medicare and some level of Medicaid benefits. Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

<http://www.cms.gov/apps/glossary/default.asp?Letter=C&Language=English>

Enrollment Broker

An independent organization that assists individuals in choosing and enrolling in a health plan.

End-Stage Renal Disease (ESRD)

Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Fee-For-Service (FFS)

A method of payment in which the organization is paid for providing services to consumers solely through fee-for-service payments plus in most cases, a case management fee.

Full Dual Eligibles

Individuals that qualify for full Medicaid benefits, including long-term care provided in both institutions and in the community as well as prescription drugs. For this group, Medicaid may also pay Medicare premiums and cost sharing.

Health Maintenance Organization (HMO)

A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare consumers for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Health Plan

An entity that assumes the risk of paying for medical treatments, (i.e., uninsured patient, self-insured employer, payer, or HMO).

Healthcare Effectiveness Data and Information Set (HEDIS)

Set of performance measures used by managed care to indicate health plan performance.

Home- and Community-Based Services (HCBS)

Services and supports provided to individuals in their own home or other community residential settings that promote their independence, inclusion, and productivity.

Home and Community-Based Service Waiver Programs (HCBS)

The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly, persons with physical disabilities, persons with intellectual or, developmental disabilities, and certain other adults with diseases or conditions. These programs give quality and cost effective services as an alternative to institutional care.

Home Health Care

Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, durable medical equipment (DME), such as wheelchairs, hospital beds, oxygen, and walkers, and medical supplies.

Integrated Care Workgroup (ICW)

Group of public and private stakeholders from health care services and public policy arenas that were actively involved in the development of the Demonstration model/proposal. The ICW provided valuable input in the areas of primary care, behavioral health care, and LTSS. Groups that were represented included, but were not limited to, advocacy groups, hospitals, medical providers, community providers, managed care organizations, and government and state agencies.

Intellectual Disability (ID)

Intellectual disability, also known as mental retardation, is a term used when there are limits to a person's ability to learn at an expected level and function in daily life.

Lt. Governor's Office on Aging

Administers federal funds received through the Older Americans Act and the State of South Carolina and functions as the State Unit on Aging. The funds are distributed to ten regional Aging and Disability Resource Centers/Area Agencies on Aging who then contract with local providers for services such as: home delivered and congregate meals, transportation, home care services, social adult day care services, respite, and disease prevention/health promotion.

(LIPS) Licensed Independent Practitioners

Include licensed Independent Social Workers, Psychologists, Marriage and Family Therapists, Counselors and Nurse Practitioners who can provide rehabilitative behavioral health services under the State Medicaid plan. LIPS must operate within the scope of the practitioner license and consistent with individually assigned clinical responsibilities.

Long-Term Care (LTC) or Long-Term Services and Supports (LTSS)

A wide variety of services and supports that help people meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care, as well as support

for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. In this proposal, these terms are used interchangeably.

Medicaid

The program that provides medical assistance for low-income persons that was established under the authority of Title XIX of the Social Security Act.

Medicare-Medicaid Coordination Office (MMCO)

The Medicare-Medicaid Coordination Office was established pursuant to Section 2602 of the Affordable Care Act. The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people who receive benefits from both Medicaid and Medicare (often called "dual eligibles"). Our goal is to make sure dual eligible consumers have full access to seamless, high quality health care and to make the system as cost-effective as possible. The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across federal agencies, States and stakeholders to align and coordinate benefits between the two programs effectively and efficiently. We partner with States to develop new care models and improve the way dual eligibles get health care (<http://www.cms.gov/medicare-medicaid-coordination/>).

Medicare

Title XVIII of the Social Security Act, the federal health insurance program for people age 65 and older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD, permanent kidney failure requiring dialysis or a kidney transplant). Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare consumers with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides coverage for most pharmaceuticals.

Medicare Model Diagnostic Categories

Categories composed of specific disease diagnoses. South Carolina used the chronic disease diagnostic categories to provide a summary of the disease occurrence in certain regions of the state, classified according to projected disease burden cost.

Money Follows the Person (MFP)

A demonstration with the purpose of making long-term support systems changes within states. This initiative will assist states in efforts to reduce the reliance on institutional care, while developing community-based long-term care services, thus enabling the elderly and people with disabilities to remain engaged in the community. Grants were awarded to thirty states and the District of Columbia proposing to transition individuals out of institutional settings over a five-year demonstration period.

NCQA

National Committee on Quality Assurance

Office of Long Term Care and Behavioral Health Services

The Office of Long Term Care and Behavioral Health Services is responsible for all long term care programs, both institutional and community-based, for the elderly and other special needs populations within SCDHHS. The Office consists of the Bureau of Community Long Term Care (CLTC), the Bureau of Community, Facility and Behavioral Health Services, and Bureau of Community Options.

Patient-Centered Medical Home (PCMH)

The PCMH is a team-based model of care in a health care setting that provides coordinated patient care to maximize health outcomes. A PCMH is responsible for providing all of a patient's health care needs. Health information technology is used to facilitate care. There are three levels of recognition for a PCMH, with three being the highest.

Program of All-Inclusive Care for the Elderly (PACE)

A comprehensive service delivery and financing model that integrates medical and LTSS under dual capitation agreements with Medicare and Medicaid. South Carolina's PACE program is limited to individuals age 55 and over who meet the skilled-nursing-facility level of care criteria and reside in a PACE service area. Two PACE programs operate in four counties within South Carolina.

Region-1

The proposed implementation region that is comprised of Allendale, Beaufort, Berkeley, Calhoun, Charleston, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Florence, Georgetown, Hampton, Horry, Jasper, Lee, Marion, Marlboro, Orangeburg, Sumter, and Williamsburg counties.

Region-2

The proposed implementation region that is comprised of Abbeville, Aiken, Anderson, Bamberg, Barnwell, Cherokee, Chester, Greenwood, Edgefield, Fairfield, Greenville, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Oconee, Pickens, Richland, Saluda, Spartanburg, Union, and York counties.

State Health Insurance Program (SHIP)

A service provided by the Lt. Governor's Office on Aging that assists seniors and adults with disabilities in accessing health insurance coverage, including Medicaid and Medicare Parts A, B, C, and D, the prescription drug program.

South Carolina Department of Health and Human Services (SCDHHS)

South Carolina's State Medicaid Agency, a cabinet level division of South Carolina State Government.

Appendix R

Letters of Support

1. State of South Carolina Office of the Governor
2. State of South Carolina Office of the Lieutenant Governor
3. AARP South Carolina
4. Absolute Total Care®
5. Alzheimer's Association South Carolina Chapter
6. BlueChoice® HealthPlan of South Carolina
7. CarePro Health Services
8. Greenville Hospital System University Medical Center
9. Greenville Hospital System University Medical Center
10. LeadingAge™ South Carolina
11. Lutheran Homes of South Carolina
12. Palmetto SeniorCare Palmetto Health (PACE Program)
13. Palmetto Physician Connections
14. Protection & Advocacy for People with Disabilities, Inc
15. South Carolina Association of Personal Care Providers (SCAPCP)
16. South Carolina Association of Personal Care Providers (SCAPCP)
17. South Carolina Health Care Association (SCHCA)
18. South Carolina Home Care & Hospice Association
19. South Carolina Hospital Association (SCHA)
20. South Carolina Institute of Medicine & Public Health (IMPH)
21. South Carolina Primary Health Care Association (SCPHCA)
22. South Carolina Respite Coalition
23. South Carolina Solutions
24. State of South Carolina Department of Mental Health (DMH)
25. The Carolinas Center for Hospice and End Of Life Care
26. UnitedHealthcare® Community Plan



State of South Carolina
Office of the Governor

NICKI R. HALEY
GOVERNOR

1205 PENDLETON STREET
COLUMBIA 29201

May 24, 2012

Ms. Melanie Bella
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Mail Stop: Room 315-H
Washington, D.C. 20201

Dear Ms. Bella,

I am writing you in support of the Draft Dual Eligible Demonstration Proposal submitted by the South Carolina Department of Health and Human Services (SCDHHS). This demonstration affords South Carolina the opportunity to establish innovative approaches to the delivery of Medicare and Medicaid services to our beneficiaries.

South Carolina's dual eligible beneficiaries receive health care services in a variety of settings and from a diverse body of health care providers. Like other states across the U.S., South Carolina's dual eligibles represent the most chronically ill beneficiaries and account for a large portion of the Medicaid program's annual spending. Today, despite significant advancements in medicine and technology, there is inconsistency in the quality of care—presenting challenges to a truly integrated and coordinated system of care. The alignment of Medicare and Medicaid, along with the convergence of primary, behavioral, and long-term services and supports, is considered one approach to the advancement of health care quality.

Designing a new model of care unique to South Carolina requires broad strategic planning, stakeholder engagement, and a public-private collaborative. In order to ensure the successful statewide implementation of this demonstration, a specific effort was made to establish an advisory group with representation from across the medical, academic, and public policy arenas. The allocations made for this extensive stakeholder engagement have been essential in advance of this strategic effort. It is clear that this demonstration proposal has been built around communal principles and tenets necessary for achieving a fully-integrated system of care. Such collaboration will continue to be the hallmark of our strategic planning efforts.

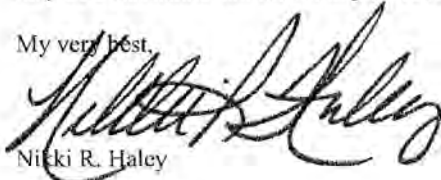
Letter of Support from State of South Carolina Office of the Governor Nicki R. Haley Page 2

Ms. Bella
May 24, 2012
Page 2

In conclusion, this demonstration is an essential component of our commitment to managing the costs and improving care coordination and health outcomes for all Medicaid beneficiaries within South Carolina. Throughout the course of this planning phase, the Medicare-Medicaid Coordination Office (MMCO) has been a consistent presence in this effort and has served to foster a collaborative approach in all aspects of design and development of this demonstration proposal. We look forward to enhancing this innovative partnership that will support effective strategies for improving the quality of care for all dual eligibles in South Carolina.

Thank you for your consideration of this matter; please do not hesitate to contact me if I may be of assistance on this or any other issue.

My very best,

A handwritten signature in black ink, appearing to read "Nicki R. Haley", written in a cursive style.

Nicki R. Haley

NRH/jdb

Letter of Support from State of South Carolina Office of the Governor Tony Kester



State of South Carolina Office of The Lieutenant Governor

Glenn McConnell
Lieutenant Governor

Office on Aging
Tony Kester
Director

May 21, 2012

Tony Keck, Director
SCDHHS
P.O. Box 8206
Columbia, SC 29202

Dear Mr. Keck:

The Lt. Governor's Office on Aging (LGOA) is pleased to submit this letter in support of the South Carolina Department of Health and Human Services (DHHS) application for a Center for Medicare and Medicaid Innovation Grant to Demonstrate the Integration of Care for Dually Eligible Individuals (SC DuE). We applaud your model which provides the opportunity to address the weaknesses in the current system by realigning incentives to allow Medicare and Medicaid services to work in a single system.

The LGOA is the State Unit on Aging and is responsible for administering Older Americans Act funding. We work with a network of regional and local organizations to develop and manage programs and services to improve the quality of life for our older adults and to help them remain independent in their homes and communities as long as possible. This delays or eliminates the need for more costly institutional long-term care and avoidable hospital stays. Each year, we help approximately 34,000 older adults who have the greatest social, economic and health needs as well as those in rural areas and low-income older adults. In addition, the LGOA works with many other state agencies, as well as the private sector to coordinate the needs and interests of older adults and to develop new resources.

There are approximately 916,000 older South Carolinians, of which 68,000 meet the eligibility criteria for this proposed program. During the past year, the aging network assisted 16,368 Dual Eligibles through the State Health Insurance Assistance Program (SHIP). These same SHIP Counselors as well as the Information and Referral Specialists at the Aging and Disability Resource Centers (ADRCs) will be able to assist these older adults access services such as primary care, behavioral health services, evidence-based prevention programs and LTC services, while lowering the cost of their care.

The LGOA has had a long history of collaboration with DHHS through programs such as SHIP, ADRCs, MFP, MDS 3.0 Section Q and SC DuE. The Deputy Director for Aging Services is a member of the Integrated Care Workgroup and will continue on that committee during the implementation phase. Your proposed model fits well into our mission and we very much look forward to working with you in its implementation across South Carolina.

Cordially,

A handwritten signature in black ink, appearing to read "Tony Kester".

Tony Kester
Director



AARP South Carolina T 1-866-389-5655
1201 Main Street F 803-251-4374
Suite 1280 www.aarp.org/sc
Columbia, SC 29201

South Carolina Dual Eligible Demonstration Proposal
Letter of Support

May 25, 2012

Nathaniel Patterson
SCDuE Project Director
S.C. Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

Dear Director Patterson,

AARP South Carolina is delighted to be included in the South Carolina Dual Eligible Demonstration initiative. We have worked closely with the South Carolina Department of Health and Human Services on many issues related to better care of older people and people with disabilities in our state. Director Tony Keck and Deputy Director Sam Waldrep continually demonstrate a spirit of collaboration and partnership with AARP and the other advocates for improved health care. This strong teamwork will improve our chances of successfully coordinating the care of Dual Eligibles.

The AARP Policy Book states, "Acute, chronic, and long-term care services should be coordinated and integrated to ensure a continuum of care throughout an individual's lifetime. Providers and patients should work together to coordinate the delivery of all health care services and support in order to address effectively an individual's multiple and/or changing health care needs and to avoid disruption. Providers, individuals, and caregivers should work together to meet all patient-care needs. Payers, including governments, should create incentives for care coordination, appropriately compensate all service providers, and assist with resource integration."

In addition, our policy encourages the following, "Containing unproductive health care spending and cost growth should be a shared responsibility. Providers, purchasers, government, and consumers all have a role to play. Design of the delivery system, health benefits, and provider reimbursement can potentially contribute to improving health care quality and efficiency while eliminating waste and inappropriate care. Changes in these areas should be grounded in strong scientific evidence in order to inform both consumers' and providers' decisions about appropriate care. To achieve cost containment over the long term, government and the private sector will need to invest in an infrastructure to support quality improvement and cost containment through solid evidence, tools to broadly assess performance, adoption of effective health information technology, and aligning payment incentives with quality and reduced costs."

We want to commend both the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services for tackling these huge issues through the Dual Eligible Demonstration Projects. Improving care and containing costs are not mutually exclusive as research has shown and SCDuE is a critical first step in the transformation of our health care system.

Because this population is among the frailest and most vulnerable, AARP is committed to ensuring that any transition to a new system is seamless and improves their quality of care and quality of life. Enrollment and continuity of care, grievances and appeals, oversight and accountability, and

Letter of Support from AARP South Carolina Page 2

evaluation and quality metrics are key areas that we will work with SCDHHS to insure that those processes meet high standards.

We appreciate the opportunity to voice our support of a system that can better coordinate the care and improve the health of dual eligibles and look forward to working closely with SCDHHS.

Sincerely,

A handwritten signature in black ink that reads "Jane Wiley". The signature is written in a cursive, flowing style.

Jane Wiley, State Director
AARP South Carolina

Letter of Support from Absolute Total Care Page 1

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TOTAL

South Carolina
HealthyConnections



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May 24, 2012

South Carolina Department of Health and Human Services (SCDHHS)
Attn.: Sam Waldrep, Deputy Director, Long Term Care and Behavioral Health Services
P.O. Box 8206
Columbia, SC 29202

Re: Letter of Support – Dual Eligible Demonstration Project

Dear Mr. Waldrep:

On behalf of Absolute Total Care (ATC), I am pleased to provide this letter of support for the South Carolina Department of Health and Human Services for submission to the CMS' Center for Medicaid and Medicare Innovation. As a managed care organization with a vested interest in the betterment of our citizens' healthcare in South Carolina, ATC believes the introduction of the Dual Eligible Demonstration Project will improve access, quality and cost of care for individuals with chronic and complex health conditions.

We have reviewed the draft proposal and support the approach outlined by SCDHHS designing an approach to care that better aligns Medicare and Medicaid services through high intensity care management, integration of funding streams, technology and the delivery of services to reduce fragmentation and confusion among this highly vulnerable population.

Absolute Total Care is confident that SCDHHS will utilize every opportunity to enrich South Carolina's healthcare system. Furthermore, we are enthused about continuing our collaboration with SCDHHS to see this project fulfilled.

If you need more information concerning our recommendation, please let me know.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul Accardi".

Paul Accardi
Chief Operating Officer
Absolute Total Care
1-803-933-3638

**SOUTH CAROLINA
CHAPTER OFFICES**

Anderson (Main) Office:
4124 Clemson Blvd
Suite L
Anderson, SC 29621
864.224.3045
800.273.2555 (toll free)
864.225.1387 (fax)

Greenville Area Office:
301 University Ridge
Suite 5000
Greenville, SC 29601
864.250.0029
866.844.0995 (toll free)
864.250.0807 (fax)

Lowcountry Area Office:
2090 Executive Hall Rd
Suite 130
Charleston, SC 29407
843.571.2641
800.860.1444 (toll free)
843.571.6020 (fax)

Midlands Area Office:
3223 Sunset Blvd, Suite 100
West Columbia, SC 29169
803.791.3430
800.636.3346 (toll free)
803.791.8388 (fax)

Myrtle Beach Area Office:
1039 44th Ave North
Suite 201
Myrtle Beach, SC 29577
843.213.1516
843.213.1529 (fax)

Spartanburg Area Office:
901 South Pine St
Spartanburg, SC 29302
864.542.9998
800.908.9690 (toll free)
864.542.0833 (fax)



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alzheimer's association®

May 16, 2012

Nathaniel Patterson, SC DuE Project Director
SC Department of Health & Human Services
P.O. Box 8206
Columbia, SC 29202

RE: South Carolina Demonstration Proposal Draft Public Comments

Dear Nathaniel:

The Alzheimer's Association, South Carolina Chapter, would like to convey our thanks to you and the Department of Health and Human Services for your leadership on the SCDuE demonstration project. We are pleased to see that the proposal reflects the spirited discussions of the SCDuE workgroup.

We applaud the holistic approach to care integration, especially the engagement of family caregivers in the multidisciplinary care team functions, including care planning, care compliance, and educational opportunities. This is critical for improving health outcomes for persons with Alzheimer's disease or related dementia. Considering that individuals with Alzheimer's disease cost Medicaid nineteen times more than those without dementia, and cost Medicare three times more, integrating care and financing for dual eligibles is of tremendous importance. (Source: Alzheimer's Association, 2012 Alzheimer's Disease Facts and Figures, Alzheimer's & Dementia, Volume 8, Issue 2)

We also applaud the commitment to provide home and community based services for everyone in the demonstration who meet service criteria with no waiting list. We are particularly interested in the proposal to provide enhanced services, such as home delivered meals, homemaker services and adult day care, to participants prior to their meeting nursing facility level of care. These types of supports can help family caregivers keep their loved ones with dementia at home for as long as possible before seeking more costly institutional levels of care. We encourage you to consider caregiver respite as a potential enhanced service for enrollees, based on their risk level.

While we understand the need to enroll a "critical mass" of participants in order to ensure adequate provider networks, we are concerned that the passive enrollment system may result in confusion for individuals with dementia. Dementia must be considered as a potential barrier to successful outreach, and should be addressed along with other considerations that have been identified, such as low reading level, alternative language, or visual challenges. Further, we have two specific questions related to the passive enrollment proposal:

1. Will these automatically enrolled individuals have the opportunity to be advised by the Enrollment Banker as to the best plan for them?
2. Will the outreach and enrollment process be open to the involvement of family caregivers?

alzheimer's association®

SOUTH CAROLINA CHAPTER OFFICES

Anderson (Main) Office:

4124 Clemson Blvd
Suite L
Anderson, SC 29621
864.224.3045
800.273.2555 (toll free)
864.225.1387 (fax)

Greenville Area Office:

301 University Ridge
Suite 5000
Greenville, SC 29601
864.250.0029
866.844.0995 (toll free)
864.250.0807 (fax)

Lowcountry Area Office:

2090 Executive Hall Rd
Suite 130
Charleston, SC 29407
843.571.2641
800.860.1444 (toll free)
843.571.6020 (fax)

Midlands Area Office:

3223 Sunset Blvd, Suite 100
West Columbia, SC 29169
803.791.3430
800.636.3346 (toll free)
803.791.8388 (fax)

Myrtle Beach Area Office:

1039 44th Ave North
Suite 201
Myrtle Beach, SC 29577
843.213.1516
843.213.1529 (fax)

Spartanburg Area Office:

901 South Pine St
Spartanburg, SC 29302
864.542.9998
800.908.9690 (toll free)
864.542.0833 (fax)



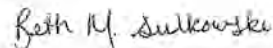
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Care coordination will be the key to successful implementation of this demonstration, and we are pleased to see that it will begin with a comprehensive needs assessment, including caregiver assessment for high risk individuals. Since half or more of individuals meeting specific diagnostic criteria for dementia have never received a diagnosis, we would like to see this needs assessment include detection and diagnosis of cognitive impairment and dementia. Wherever cognitive impairment or dementia is present, that must be the starting point for care coordination and a key consideration for addressing other health concerns.

Finally, the demonstration proposal states that CICOs will ensure that providers in their networks have demonstrated expertise with complex geriatric populations. We would like to see this include a standard level of understanding of dementia. Too often direct care staff are unprepared to address the unique needs and challenges of a patient with dementia.

The Alzheimer's Association is pleased to have been part of the SCDuE workgroup, and we would like to continue to support this effort as it unfolds. Please contact me at our Spartanburg Area Office if our chapter can assist in obtaining further beneficiary input. We are happy to do what we can to ensure this demonstration works for everyone.

Best regards,



Beth Sulkowski
Senior Director, Communications & Advocacy
Alzheimer's Association
South Carolina Chapter

Letter of Support from BlueChoice HealthPlan of South Carolina



May 23, 2012

Nathaniel Patterson
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29202

Dear Nate,

Thanks for coordinating the Dual Eligible Workgroup meetings over the last several months and for allowing an opportunity for stakeholders to provide input into the design of the South Carolina demonstration. I appreciate the opportunity to collaborate on ways to effectively manage the Dual Eligible population. Having reviewed the draft Dual Eligible proposal, I am very excited to see the patient-centered medical home (PCMH) be the core foundation for this initiative. Additionally, having multiple stakeholders involved on the PCMH team, including non-physician care managers, is an important part of effective care management for this population. Though we are far from implementation and challenges remain, I think we are off to a good start and I look forward to further collaboration to ensure this demonstration is successful.

Sincerely,

A handwritten signature in black ink, appearing to read "Scott Graves".

Scott Graves
Vice President, Medicaid Managed Care
BlueChoice HealthPlan

Letter of Support from CarePro Health Services



P.O. Box 2626
Columbia, SC 29202

Home Health, Hospice and Private Duty & Staffing Divisions

1800 Main St. Suite 100
Columbia, SC 29201
Tel. 803.758.4000
Fax 803.758.4001

Referral Line
800.275.9245
800.276.5168

Branch Offices

CarePro Health Services
2175-F Ashley Phosphate Rd.
N. Charleston, SC 29407
Tel. 843.569.0033
Fax 843.569.0062

CarePro Health Services
1901 Laurens Rd. Suite G
Greenville, SC 29607
Tel. 877.696.6331
Fax 864.250.0037

CarePro Health Services
1924 India Hook Road
Rock Hill, SC 29732
Tel. 800.579.6331
Fax .803.980.4365

CarePro Health Services
109 Laurel St.
Florence, SC 29501
Tel. .800.815.6331
Fax 843.667.4746

CarePro Health Services
1021 15th St. Suite 1
Augusta, GA 30901
Tel. 706.774.0042
Fax 706.774.0007

www.careprohh.com

May 22, 2012

Nathaniel Patterson
SC DUE Project
SC Department of Health and Human Services
P.O. Box 8206
Columbia, S.C. 29202

Dear Mr. Patterson,

I am pleased to write this letter of support for South Carolina's application for funding under the Centers for Medicare and Medicaid Services (CMS) Innovations Center "State Demonstration Initiative to Integrate Care for Dual Eligible Individuals".

Persons dually eligible for Medicare and Medicaid in South Carolina are among the poorest, sickest and most frail in our State. Often times care is fragmented and uncoordinated for this population of people resulting in poor outcomes. The proposed design will include all of the Health Home services including: comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate.

We have been working with Community Long Term Care as a provider of Personal Care Services for over 20 years. Our Company also provides Home Health and Hospice Services. I am most pleased that the focus of this initiative will be on coordinating care and services and will not adversely affect client care.

We look forward to continuing our work with you through a successful SCDuE Project.

Sincerely,

Valerie M. Aiken
State Director

Letter of Support from Greenville Hospital System University Medical Center



GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER

May 24, 2012

SC Dual Eligible Proposal Public Comments
C/O Nathaniel Patterson
S.C. Dept. of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

Dear Director Anthony Keck:

I am writing to express my support of the South Carolina Dual Eligible (SCDuE) Demonstration Project. I have had the opportunity to be involved in the work group meetings, and feel like the project will help address the issues surrounding the dual eligibles in South Carolina.

Currently the Medicare and Medicaid programs are not coordinated and this project will help improve the system by aligning incentives to encourage the two programs to work as one. Another major focus of SCDuE will be to increase access to primary care, behavioral health and long-term care services for seniors in our state. Access to healthcare remains a constant issue, and the SCDuE project will help solve this problem by improving care coordination for a population with chronic conditions.

By improving care coordination, providing home- and community-based care and transforming healthcare through payment reform the SCDuE Demonstration Project will produce improved health outcomes.

Please let me know how Greenville Hospital System can help support and be a part of this unique project.

Sincerely,

A handwritten signature in black ink, appearing to read "Angelo Sinopoli", written over a white rectangular background.

Angelo Sinopoli, MD
VP, Clinical Integration
Chief Medical Officer

Letter of Support from Greenville Hospital System University Medical Center



May 24, 2012

Nathaniel J. Patterson, MHA
Project Director
S.C. Dept. of Health & Human Services
1801 Main Street
Columbia, SC 29201
(803) 898-2018 | Office
(803) 255-8209 | Fax
pattnat@scdhhs.gov

Mr. Patterson and Mr. Waldrep,

I am writing this message in support of the proposed South Carolina Dual Eligible Demonstration Project. The benefits of this proposal are multi-faceted;

- 1) Coordination of Medicaid and Medicare programs and benefits for our SC residents.
- 2) Improved access to care and services for our most vulnerable residents. Continuity of care and enhanced access to care for our dual eligible residents will support better long term health outcomes.
- 3) Improved efficiencies between services and agencies will result in better forecasting for budgeting and programs. The proposed Dual Eligible Demonstration project will alleviate gaps between programs as well as reduce costs and duplication between existing programs.
- 4) Better transitions in care between the many settings and programs that exist today for those with chronic healthcare needs. Examples include; enhanced access to a primary care provider, continuity of care for the resident, and focused medication management.

As an active member of the task force involved in the development of this proposal, I have been impressed with the diversity of broad representation from healthcare clinicians, advocacy groups, agencies, and various programs from across our state. The team approach was instrumental to exploring all aspects of unmet care needs for our dual eligible residents and the development of a proposal that will enhance care coordination.

Your support for the proposed Dual Eligible Demonstration project is vital to the future for this population.

Sincerely

A handwritten signature in cursive script that reads "Grace Dotson".

Grace Dotson, RN, MS, CMAC, CPUR
Director, Hospital Case Management
864-455-7940

GREENVILLE HOSPITAL SYSTEM UNIVERSITY MEDICAL CENTER
701 GROVE ROAD • GREENVILLE, SC 29605 • (864) 455-7000

GHS.ORG  

Letter of Support from Leading Age South Carolina



May 22, 2012

Mr. Nathaniel Patterson
SC DHHS
Post Office Box 8206
Columbia, SC 29201

Dear Mr. Patterson:

On behalf of LeadingAge South Carolina, it is my pleasure to write this letter of support for the South Carolina Dual Eligible Demonstration Proposal (SCDuE). LeadingAge South Carolina is a not-for-profit association representing not-for-profit providers of long term care that includes retirement housing, assisted living, skilled nursing, hospice and home health for the elders of South Carolina.

One of the key benefits to implementing the DuE program in South Carolina would be providing access to persons for needed services such as primary care, behavioral health and long term care. These persons typically have chronic conditions that require coordinated care and the DuE would provide this option with the potential of improved health outcomes.

We see as one of the most important opportunities for the SCDuE is the coordination between Medicare and Medicaid. These programs do not currently provide quality coordinated care and are most often confusing to the population they serve. It would be a great opportunity to for South Carolinians to have the option of being a part of a new concept implementing a fresh approach to services and care.

Having been a member of the SCDuE workgroup for the past year, it has been a great opportunity to learn more about the DuE project and the benefits it would provide to our South Carolinians. We encourage you to allow the SCDuE program to move forward by approving the proposal and thank you for the opportunity to provide support.

Most Sincerely Yours,

Vickie

Vickie L. Moody
President/CEO

Letter of Support for Lutheran Homes of South Carolina



Lutheran Homes
of South Carolina

promoting the well-being of older adults

300 Ministry Drive o: 803.749.5110
Irmo, SC 29063-2366 f: 803.749.5111
w: lutheranhomessc.org

May 22, 2012

Anthony Keck, Director
SC Department of Health and Human Services
1801 Main Street
Columbia, SC 29201

Re: SC Dually Eligible Proposal

Dear Director Keck:


South Carolina's Dually Eligible (SCDuE) Demonstration proposal will make fundamental changes in South Carolina's health care delivery system. While the plan is aggressive and may contain elements that some organizations and individuals find objectionable, the goals of improving health care quality and containing cost of care through coordination of Medicare and Medicaid services for some of the state's most needed residents are achievable.

The state has been fortunate to have the experience of a fully integrated PACE program, Palmetto SeniorCare, to see firsthand the advantages of better coordinated care between Medicare and Medicaid for a nursing home eligible population. And, while SCDuE's target population is somewhat different and often underserved, health care delivery process measures and health outcomes for the thousands of non-institutionalized individuals this less frail population should improve.

SCDuE's target group includes individuals who will benefit from a more coordinated health care delivery system and who are likely to enroll in the program. From my personal research approximately 20 years ago as part of the Social HMO demonstration, we learned that non-institutionalized dually eligible South Carolinians would very likely enroll "in an organized system of care in which all health care providers knew about my health care needs and worked together to address them". Based on this research and assuming that today's non-institutionalized dually eligible population is similar to the same category of dually eligible individuals in the early 1990's, I believe the "opt out" system of enrollment will be very successful, and SCDuE's enrollment goals will be met.

Thank you for inviting me to participate in the planning and development process.

Sincerely,


Thomas E Brown, Jr, DrPH
President and CEO

Letter of Support for Palmetto Health



May 22, 2012

Anthony Keck, Director
SC Department of Health and Human Services
1801 Main Street
Columbia, SC 29201

Re: SC Dually Eligible Proposal

Dear Mr. Keck:

South Carolina's Dually Eligible (SCDuE) Demonstration proposal will address the health care of many South Carolina's most vulnerable population. While the challenges of linking Medicare and Medicaid into a single seamless model of care are daunting, it is essential that the state gain experience in managing care for this population in order to weather the reduction in financial resources. This will require providers and payers collaborating together to design processes of care that efficiently and effectively address the needs of a dual eligible population.

For the last 25 years, South Carolina has had in place a PACE program, Palmetto SeniorCare which not only represents the epitome of a medical home but effectively coordinates care for a Medicare and Medicaid, nursing home eligible population. The SCDuE's target population is non-institutionalized individuals that are less frail than PACE, never the less, much of the infrastructure of PACE has applicability to the duals. PACE has much to offer providers and payers to learn from as a different network of care is developed to meet the needs of an older and frailer population than has been traditionally served in a managed care model in South Carolina. Payers who have no experience managing this population must understand the infrastructure that is needed and be willing to support that infrastructure, so that providers are capable of managing care and risk for the population.

On behalf of Palmetto SeniorCare, we offer support of this endeavor and are willing to assist with the process in any way necessary to make it successful. Thank you for the opportunity to be part of the development process.

Sincerely,

Judy Baskins
Vice President, Clinical Integration and Post Acute Care
Palmetto Health



May 11, 2012

Nathaniel J. Patterson, MHA
SCDuE Project Director
South Carolina Department of Health and Human Services
1801 Main Street, Room 719
Columbia, SC 29201

Sent Via E-Mail

RE: *South Carolina Demonstration Proposal Draft Public Comments:
Letter and Support and Questions*

Dear Mr. Patterson:

Thank you for seeking comments regarding the South Carolina Dual Eligible Demonstration Proposal. Palmetto Physician Connections ("PPC") is proud to be an SCDuE-ICW member and to work with you and your team to help design and launch the program.

As a Greenville, SC based statewide Medical Homes Network ("MHN") plan in the State, we currently provide care coordination for South Carolina Dual Eligible beneficiaries. We understand firsthand the value and importance of care coordination for our members. We recognize that Dual Eligible members are some of the most vulnerable residents in our state and need additional services and benefits as outlined in the SCDuE Proposal.

We believe we are in a unique position to advocate for this new program firsthand with our provider network that spans all 46 South Carolina counties in the State. In our current care coordinating relationship, as the MHN for our Dual Eligible members, we can and will be able to advocate the benefits this new program will offer for the patient, the provider and the State at large in our day to day work with providers and our members whom will be part of the transition in all three regions.

To that end, PPC is in full support of this initiative described in the proposal.

Let us also please take this opportunity to submit nine (9) questions.

Letter of Support from Palmetto Physician Connections Page 2

Mr. Nathaniel J. Patterson
May 11, 2012
Page 2 of 3

1. The proposal indicates that the implementation will be rolled out in geographic regions based on dates beginning January 2014 and going statewide in January 2015. Will the state consider the experiences of each phase prior to expanding to other phases and statewide in order to mitigate any issues that are identified during rollout?
2. Since the Coordinated and Integrated Care Organization (CICO) is not currently a recognized entity with the Department of Insurance (DOI), what DOI standards will need to be met in order to meet participation requirements as a CICO management entity?
3. The proposal acknowledges that sufficient enrollment and consumer choice of CICOs are key aspects to an improved service delivery system. To that end, how many CICOs does the state plan to contract with to serve this population?
4. The proposal indicates that CICOs will be encouraged to offer supplemental benefits currently not covered or that are limited in existing benefit packages. Will the assumptions used to establish a capitation payment include any of the proposed additional services outlined in Appendix E?
5. In order to achieve maximum coordination and integration, would the agency consider including the home and community based waiver system services in the capitation rate? Excluding the home and community based services from the capitated payment while including the nursing home payments could result in duplication and greater costs to the state.
6. In anticipation of network development and negotiating provider reimbursement rates, will the capitation rate be based on the Medicaid fee schedule or will the rate be based using the Medicare base rate?
7. Will signed provider agreements and/or signed provider letters of intent be need to be submitted with the RFP? If not, when will provider agreements need executed?
8. We understand the enrollment will be passive. But will this program also allow for a sales enrollment process through the use of licensed sales agents as seen with Medicare Advantage plans?
9. Considering the need to help South Carolina maintain as many jobs as possible in the State, will the RFP allow for preferential points / additional points for South Carolina domiciled CICOs that will maintain most if not all of their workforce for this program in the State?

* * *

Letter of Support from Palmetto Physician Connections Page 3

Mr. Nathaniel J. Patterson
May 11, 2012
Page 3 of 3

We look forward to the potential to expand our relationship with the South Carolina Department of Health and Human Services, which undoubtedly will expand service delivery to Medicaid beneficiaries and service to the community.

Sincerely,

A handwritten signature in black ink, appearing to read "Cesar D. Martinez". The signature is written in a cursive style with a large initial "C".

Cesar D. Martinez
Chief Executive Officer

CC: Gerald E. Harmon, MD, Medical Director, PPC



The Protection & Advocacy System for South Carolina

May 24, 2012

Mr. Anthony Keck, Director
S.C. Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

By email and U.S. Mail

Re: Letter of Support for Dual Eligible Demonstration Grant

Dear Director Keck:

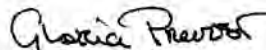
Protection and Advocacy for People with Disabilities, Inc. (P&A) is the nonprofit organization designated by state and federal law to advocate on behalf of beneficiaries with disabilities, including adults with disabilities over age 65 who receive both Medicare and Medicaid (dual eligibles). P&A supports the goals of the demonstration grant to keep people in their homes and communities, ensure that recipients receive coordinated care, and reduce costs. We appreciated the opportunity to participate in committees and a public hearing, and to have the opportunity to submit comments during the development of the grant proposal.

As you are aware, we support meaningful participation by both consumers and advocates for beneficiaries in all stages of development of the waiver, including design of the enrollment/opt-out process and the grievance and appeal process.

We are pleased that there are plans for advocacy and community groups as well as SCDHHS and the MCAC to carefully review all marketing materials to ensure that accurate easily understood information is provided.

P&A looks forward to working with SCDHHS so that the demonstration grant results in dually eligible individuals with disabilities continuing to live in their homes and communities. If additional information is needed, please contact me at prevost@pandasc.org or at 803.217.6713.

Very truly yours,


Gloria Prevost
Executive Director

CENTRAL OFFICE
SUITE 208
3710 LANDMARK DRIVE
COLUMBIA, SC 29204
(803) 782-0639
(Voice and TTY)
FAX (803) 790-1946

PIEDMONT OFFICE
SUITE 106
545 N. Pleasantburg Drive
GREENVILLE, SC 29607
(864) 235-0273
1-800-758-5212
(Voice and TTY)
FAX (864) 233-7962

INFORMATION AND REFERRAL
Toll Free:
1-866-275-7273
(Voice)
1-866-232-4525
(TTY)
Email:
info@pandasc.org

PEE DEE OFFICE
1801 D WEST EVANS STREET
SUITE 101
FLORENCE, SC 29501
1-843-656-0019
(Voice and TTY)
FAX (843) 662-0745

LOW COUNTRY OFFICE
1569 SAM RITTENBERG BLVD.
CHARLESTON, SC 29407
(843) 763-8571
1-800-743-2553
(Voice and TTY)
FAX (843) 571-0880

Letter of Support from SCAPCP John Belissary dated May 4, 2012

May 4, 2012

Nathaniel Patterson
SC Dual Eligible Proposal Public Comments
SC Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

SCAPCP

Dear Nate:

On behalf of the SC Association of Personal Care Providers and as a member of the DuE Work Group, I am pleased to offer comments regarding the draft proposal. SCAPCP very much appreciates the efforts by the Department of Health and Human Services to rebalance Medicaid dollars to ensure our state's seniors and disabled population have the resources to remain in their homes. Home and community based services promote high quality care, higher quality of life, reduce Medicaid costs and reduce the need for more expensive institutional care. We are certain this demonstration grant will serve as an impetus to rebalance our community long term care dollars and will result in better health outcomes.

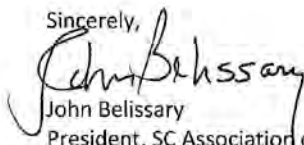
We endorse the draft report and look forward to working with the agency in the future as it explores the possibility of moving more home and community based services under the umbrella of managed and/or coordinated care. We appreciate the agency's approach of working with a smaller group, i.e. the dual eligible age 65 and older in order to ensure implementation is done appropriately to promote the best outcomes.

While we are not opposed to being part of the larger managed care umbrella, we do have reservations if the implementation is not done correctly. We believe it is imperative that managed care organizations have a clear understanding of home and community based services and that there are sufficient resources available. We stand ready to be a part of any education process and discussions relative to potential changes.

We are open to any discussions that will improve access and quality of care for the people we serve. As ideas continue to be debated we would like to emphasize that strong state oversight of managed care organizations (MCOs) is essential, and quality measures are of paramount importance. We would stress that the ideal would be strong and effective state oversight of the managed care organizations.

We appreciate the opportunity to be a part of this process and look forward to continuing to work with DHHS.

Sincerely,



John Belissary
President, SC Association of Personal Care Providers
2111 West Jody Road
Florence, SC 29501
(843) 629-0103

Letter of Support from SCAPCP John Belissary Dated May 16, 2012

May 16, 2012

Nathaniel Patterson
SC Dual Eligible Proposal Public Comments
SC Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

SCAPCP

Dear Nate:

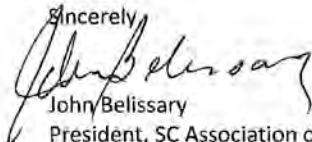
After additional review and consideration, the SC Association of Personal Care Providers would like to provide additional comments regarding the Dual Eligibles Demonstration Grant. The association requests that SCDHHS consider as part of the Dual Eligibles Demonstration Grant inclusion of Community Long Term Care (CLTC) waiver recipients over age 65 as part of the target population for initial enrollment. We believe these consumers can benefit from the care coordination offered through the demonstration.

Home and community-based service providers can offer much in enhancing the overall care coordination for waiver consumers. CLTC providers such as personal care providers are often the only constant and regular care component. Our providers see participants more regularly than the primary care physician or any other provider. We are uniquely qualified to track the health care needs of the individuals we serve. For those individuals who do not have family, we are often the only person who sees the individual on a regular basis. We are best situated and suited to know when there is a sharp decline in health, challenges with medication or behavioral concerns. We believe personal care is a significant component of the overall health and well-being of the people we serve. Therefore we need to play a key role in any discussions related to health care needs and appropriate services. The CLTC case manager can serve as a vital link between providers and the proposed multi-disciplinary team that will be responsible for the overall care coordination.

We would prefer to allow this population to be eligible for enrollment while continuing as a carve out waiver services from the capitation. This will ensure a smoother transition towards the managed care component while making patient care the # 1 priority. This is a great opportunity for the managed care companies to learn of the benefits of in-home care but still affords consumers the opportunity to have the most appropriate access to care. And this plan would allow those of us who see participants in their homes an opportunity to be a part of the decision making process as it relates to care and specific needs of the individual.

Thank you for your consideration of this request. We appreciate the opportunity to be a part of this process and look forward to continuing to work with DHHS.

Sincerely,



John Belissary
President, SC Association of Personal Care Providers
2111 West Jody Road
Florence, SC 29501
(843) 629-0103

Letter of Support from South Carolina Health Care Association (SCHCA)



J. Randal Lee
176 Laurelhurst Ave.
Columbia, S.C. 29210
May 23, 2012

SC Dual Eligible Proposal
Nathaniel Patterson
S.C. Department of Health and Human Services
P.O. Box 8206
Columbia, S.C. 29202

Dear Mr. Patterson:

South Carolina Health Care Association is supportive of the current SCDue Proposal that has been posted for public comment.

Our current system in South Carolina for citizens dually eligible for Medicare and Medicaid has several weaknesses that hinder them to access to quality cost effective health care.

The SCDue proposal addresses the current misalignment between the two programs and encourages coordination of a seamless patient centered services which will improve access to needed services for primary care, behavioral health services and long term care services for persons with chronic health care conditions.

SCDue encourages providers to progress towards becoming a certified Patient-Centered Medical Home. Ensures care coordination and planning by an interdisciplinary team with a consumer directed component for personal services. It is committed to providing home and community based services for those citizens who meet that level of care.

Through patient centered quality cost effective coordinated services, SCDue should result in improved health outcomes for the dually eligible citizens in S.C..

Sincerely,

J. Randal Lee

President South Carolina Health Care Association

jrl/kw

Letter of Support from South Carolina Home Care and Hospice



3101 Industrial Drive
Suite 204
Raleigh, North Carolina 27609

Phone: 919.848.3450
Fax: 919.848.2355
E-mail: info@homeandhospicecare.org

May 23, 2012

Nathaniel J. Patterson, MHA
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202

Dear Mr. Patterson:


The South Carolina Home Care & Hospice Association is a thirty-three year old association representing certified home health agencies, hospices, and personal care/private duty home care agencies across the state. We have been pleased to work with you and the other members of the SCDuE Integrated Care Workgroup to develop a coordinated care model for the Medicare-Medicaid dual eligible population.

We are supportive of your efforts to increase the number of certified Patient-Centered Medical Homes and to ensure that beneficiaries receive appropriate services across the care continuum.

We share your goals of reducing avoidable emergency room visits, hospitalizations, and limiting institutional care. Our agencies are natural partners to help with implementation of your chronic disease management strategies.

Our Association of home health, home care, and hospice agencies is pleased to partner with you as this initiative moves forward.

Sincerely,



Timothy R. Rogers
Chief Executive Officer



1000 Carver Foint Road | Columbia, SC 29210-5802 | 803.796.3080 | SCHA.org

May 24, 2012

Nathaniel Patterson
SCDuE Project Director
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29201

Dear Nate:

On behalf of more than 100 member hospitals, the South Carolina Hospital Association (SCHA) applauds the efforts of CMS and the South Carolina Department of Health and Human Services (SCDHHS) to develop new ways of delivering care to vulnerable populations and to support the proposed South Carolina Dually Eligible (SCDuE) project.

We are proud that South Carolina is one of only 15 states in the country to pursue this planning grant. Our members' services include acute care, rehabilitation, long term acute care, and skilled nursing care provided by hospitals, nursing homes, home health agencies and physicians. Because our members provide almost every type of care needed by the Medicare and Medicaid Dually Eligible population, they are key stakeholders in the outcomes of this project.

Dually eligible individuals are among the most fragile South Carolina residents and suffer multiple chronic diseases. Many of these individuals do not have the support they need to navigate a complex health care system. This situation is further complicated when the two different payors have conflicting requirements. The SCHA supports the development of systems that would reduce fragmentation in the delivery of care and improve the health outcomes for these individuals.

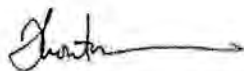
Prevention must be a major part of evolving systems. Three out of every five South Carolina adults are either overweight or obese, putting them at increased risk for diabetes, hypertension, stroke, certain cancers, heart disease, high cholesterol, gall bladder disease, sleep apnea, depression, osteoarthritis and asthma. In 2003, obesity-related medical expenditures for adults in South Carolina were more than \$1 billion, with more than half of the costs paid by Medicaid and Medicare. Obviously, as we work to bring down the cost of health care, we can't ignore costs related to bad decisions or ignorance. We have to educate our population and change behavior. Not only can it save money, but it can also improve quality of life for so many.

Letter of Support from South Carolina Hospital Association Page 2

SCHA is working with SCDHHS, along with other providers and payers in our state, on an unprecedented effort to improve the quality and safety of care delivered, control the rising costs of care, and improve the health status of our state's population. Initiatives such as this SCDuE project are vital to our overall success.

Please feel free to contact me for more input on this project at tkirby@scha.org or (803)744-3542 for any further detail or questions that you may require. Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "J. Kirby", with a long horizontal flourish extending to the right.

J. Thornton Kirby, FACHE
President & CEO

Letter of Support from South Carolina Institute of Medicine & Public Health



South Carolina Institute of
Medicine & Public Health

May 19, 2012

Nathaniel J. Patterson, MHA
Project Director, S.C. Dual Eligible (SCDuE)
S.C. Department of Health and Human Services
P.O. Box 8206
Columbia, S.C. 29202

Dear Mr. Patterson:

On behalf of the South Carolina Institute of Medicine and Public Health (SC IMPH), I am pleased to offer our support for the S.C. Department of Health and Human Services' Dual Eligible Demonstration Proposal. I am very familiar with the important objectives of this project from having participated in your numerous planning meetings and public information sessions, and I am hopeful that further funding will be made available to our state to continue your essential work.

As you know, SC IMPH acts as a nonpartisan convener and resource for evidence-based information on the important health issues in our state. It is in this role that we serve to convene the statewide long-term care workgroup, which actively supports the objectives of your project. In particular, the need to enhance the coordination of the Medicare and Medicaid programs is seen as vital, as is the effort to improve access to needed services and care. It is my belief that such advancements can only be achieved through continued collaboration and innovation among key stakeholders. The Dual Eligible Project is an important effort in achieving these advancements and, ultimately, improving health outcomes in South Carolina.

Please accept this letter with my organization's full support for your proposal. My colleagues and I look forward to working with you and the leadership of the S.C. Department of Health and Human Services as you move forward in this uniquely important effort.

Sincerely,

Joseph L. (Lee) Pearson, MS, DrPH
Director of Operations

Letter of Support from South Carolina Primary Health Care Association



"Access to Quality Health Care for All South Carolina"

May 22, 2012

SC Department of Health and Human Services
Attn: Anthony Keck, Director
P. O. Box 8206
1801 Main Street
Columbia, SC 29202-8206

Re: Letter of Support for the SC Department of Health and Human Services' Dual Eligible Demonstration Proposal

Dear Mr. Keck:

On behalf of the Board of Directors of the South Carolina Primary Health Care Association (SCPHCA), I am pleased to provide this letter of support for the SC Department of Health and Human Services' Dual Eligible (SCDuE) demonstration proposal to be submitted to the Centers for Medicare and Medicaid Services. It is my understanding that the SCDuE demonstration project seeks to better align coverage/services between the Medicare and Medicaid Programs, enhance access to needed services/care for our seniors, and improve health outcomes for beneficiaries. These efforts would not only impact the nearly 40,000 Medicare patients served by member Community Health Centers (CHC) in 2011 in a positive way, but would also assure clarity of coverage and reimbursement for dual-eligible beneficiaries for CHCs. The SCPHCA is committed to improving access to care, and is supportive of programs and initiatives that promote this objective.

The SCPHCA is the membership organization that represents all of South Carolina's CHCs, which are an integral part of the primary health care system in our state. In 2011, the 19 CHCs and the statewide migrant health voucher program provided quality, affordable, and community-based preventive and primary health care services to over 325,000 patients, nearly 110,000 of who are Medicaid beneficiaries, through 120 service sites. CHCs provide high quality comprehensive primary health and dental care to all patients while reducing inappropriate Emergency Room usage, overall health care costs, racial and ethnic health disparities, and barriers to care.

I wish you much success with your proposal. I look forward to continuing our collaborations to assure access to care for all in South Carolina.

Sincerely,


Lathan J. Woodard
Chief Executive Officer

Letter of Support from South Carolina Respite Coalition



PO Box 493
Columbia, SC 29202
(803) 935-5027
1 (866) 345-6786
screspitecoalition@yahoo.com
www.screspitecoalition.org

May 22, 2012

Mr. Sam Waldrep, Deputy Director
Long Term Care and Behavioral Health Services
SC Dept. of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

I write in support of your application for a demonstration grant to improve coordination of care for people served by both Medicaid and Medicare. With the number of elders growing by the day, this cannot be too soon! Even while attempting to hold down costs, SC Department of Health and Human Services (DHHS) has always been so innovative and responsive to the needs of families that we have confidence in your approach and efforts.

At the Respite Coalition, we see the consequences of lack of collaboration among organizations. All too often there is unnecessary duplication, other people left un-served, rules that do not work for families and individuals, or a cookie cutter approach to addressing needs. There is far too much work in silos, concerned with separate funding streams and specific constituencies. There's no time or staff allocated to listen and coordinate anything! Acknowledgement of the family, as well as the individual, as full members on the multidisciplinary team is fundamental to improved health outcomes. This has been shown time and again in the hospice model, of which I have been fortunate to be a part for several years of my career.

The more ideal health care and other service planning that work for individuals and their families, uses trained professionals – usually medical social workers and nurses – to listen carefully and pull from each system the services that meet their individual needs. I mention "other services" because family systems usually must be considered to improve individual health. We hope that in-home respite will be provided in this project and we are ready to assist in developing it.

We deeply appreciate DHHS' collaboration with the Coalition and its continued efforts to develop respite options for family caregivers. We are pleased to have served on the statewide long term care workgroup spear-headed by SC Institute of Medicine and Public Health that advises DHHS. It is our commitment to continue this partnership with DHHS and help in any way possible.

Yours sincerely,

A handwritten signature in cursive script that reads "Susan M. Robinson".

Susan M. Robinson, LMSW
Executive Director

Letter of Support from South Carolina Solutions

South Carolina
Solutions

May 24, 2012

Re: South Carolina Dual Eligible Project

To Whom It May Concern:

This letter is written in support of the South Carolina Dual Eligible Demonstration project. South Carolina Solutions has served this population over the past five years in limited numbers so we have encountered the challenges that incur when you have two separate funding "streams" that often include different policies and procedures. For this reason, the goal of establishing innovative ways to coordinate and integrate care for this Medicare/Medicaid population in a seamless fashion is worthwhile.

South Carolina Solutions believes that with this coordinated approach, the state will recognize improved and increased access resulting in improved quality of health care delivery and ultimately, a healthier population. At this same time, we believe this will stabilize costs and ensure service delivery is commensurate with the Member's needs.

We applaud the South Carolina Department of Health and Human Services for pursuing a project of this importance and will work to support them.

Sincerely,

Beverly G. Hamilton

Beverly G. Hamilton
Executive Director

132 Westpark Blvd.

◆ Columbia, SC 29210

◆ 866-793-0006 (888-893-0018 fax)

◆ sc-solutions.org

administered by:



Community Health Solutions
of America

Letter of Support from State of South Carolina Department of Mental Health



State of South Carolina Department of Mental Health

MENTAL HEALTH COMMISSION:

Nelson V. Evans, PsyD, Chair
Joan Moore, Vice Chair
Janie B. Jones
Everard Rutledge, PhD
J. Buxton Terry

2414 Bull Street • P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Health

May 23, 2012

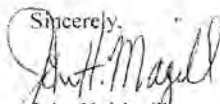
Mr. Anthony E. Keck, Director
Department of Health and Human Services
1800 Main Street
Columbia, South Carolina 29202

Dear Mr. Keck:

I am writing to offer the South Carolina Department of Mental Health's (SCDMH) support to the South Carolina Department of Health and Human Services "South Carolina's Dual Eligible (SCDuE) Demonstration Proposal." National data indicates that 68% of people with a mental health disorder also have at least one co-morbid medical problem. In addition, 29% of people with medical disorders have a co-morbid mental health condition. The combination of a mental health disorder and at least one co-morbid medical problem increases the risk of functional impairment, decreased length and quality of life and therefore increased cost.

SCDMH is committed to improving the health outcomes for adults affected by mental illnesses and working collaboratively with our state and local stakeholders to strengthen the infrastructure capacity for integrated, client-focused care within our communities. As an active member of the Integrated Care Workgroup, SCDMH strives to eliminate stigma and promote the philosophy of recovery in order to assure the highest quality of culturally competent services possible. We are committed to continuing to serve as part of the Integrated Care Workgroup and working together to identify the gaps in access to integrated primary care, behavioral health services, and long term care services for the elderly population.

We look forward to continuing the partnership between our agencies which we believe will result in increased access for South Carolinians with serious mental illness.

Sincerely,

John H. Magill
Stat Director

JHM/cm

MISSION STATEMENT
To support the recovery of people with mental illnesses.

DMH South Carolina
Department of
Mental Health



NORTH CAROLINA
1230 SE Maynard,
#203
Cary, NC 27511

PHONE
919-459-5380

TOLL FREE
800.662.8859

SOUTH
CAROLINA
1350 Browning Rd.
Columbia, SC 29210

PHONE
803.791.4220

May 21, 2012

Nathaniel J. Patterson, MHA
Project Director
S.C. Dept. of Health & Human Services
1801 Main Street
Columbia, SC 29201

Mr. Patterson,

I am writing to offer our support for the development of a model to serve our state's dually eligible population.

The Carolinas Center for Hospice and End of Life Care is a professional association providing support, education, technical assistance, advocacy and other services to the state's hospice providers for almost 40 years. We appreciate the opportunity to comment on the SC Dual Eligibles Demonstration Proposal Draft. We are obviously supportive of any model of care which impacts key goals such as consumer directed care and also promotes the provision of quality, integrated care provided in a financially viable manner.

We support the CICO and DHHS in developing a model that addresses the concerns listed below:

- o TCC is supportive of any activities or programs that increase access and timely utilization of hospice services in SC. We recognize the value of hospice care both to insure that patients and families get the care needed at the right time and that the state realizes the financial benefit demonstrated by data that hospice utilization helps the state lower costs for terminally ill beneficiaries. There are several examples of this impact including:
 - o Delay or eliminate the need for placement of terminally ill individuals in LTC facilities
 - o Avoid frequent trips to the ER and unnecessary hospitalizations
 - o Utilization of hospice and palliative care services to assure the health care continuum is utilized appropriately
- o TCC supports creating models of care that support concurrent care (curative and palliative/hospice care) for individuals with terminal illnesses that do not necessarily meet the 6 month criteria for hospice. (Similar to the pediatric concurrent care model included in the Affordable Care Act.) This would include creative utilization of hospice and CLTC services.
- o Non-hospice palliative care should be included as a service in any model developed. This focused care provided by hospice and palliative care programs early in the diagnosis of a life-threatening illness increase the likelihood that patients and families have the opportunity to develop personal goals and preferences for care which more often than not would include less costly and medically ineffective treatment.

Letter of Support from the Carolinas Center Page 2

We are certain that hospice and palliative care services are an integral part of the healthcare continuum and would support any aspects of the proposed project that encourage such significance. As the voice for hospice and palliative care in the state, we would expect to be at the table as the program is developed and implemented.

Please contact me for further information. I will gladly assist the project in any way possible including sharing data, giving access to hospice providers for education and serving on implementation workgroups or task forces.

Cordially,

Tamra N. West
Senior Director
The Carolinas Center for Hospice and End of Life Care
1350 Browning Road
Columbia, SC 29710



David Stone, President and CEO
The Carolinas Center for Hospice and End of Life Care
1230 SE Maynard Rd. Suite 203
Cary, NC 27511



Letter of Support from UnitedHealthcare



UnitedHealthcare Community Plan
100 Executive Center Drive, Ste. A-13
Columbia, SC 29210

Via email: comments@scdhhs.gov

May 24, 2012

SC Dual Eligible Proposal Public Comments
c/o Nathaniel Patterson
SC Department of Health and Human Services
P.O. Box 8206
Columbia, SC 29202

Dear Nate,

We are pleased to support the State of South Carolina's goals of improving the quality of care provided to individuals who are eligible for Medicare and Medicaid. The South Carolina Department of Health and Human Services (SCDHHS) has demonstrated strong leadership on its proposal to develop a service delivery model that integrates care for individuals who receive services from both Medicare and Medicaid. We recognize the enormity of addressing the needs of this complex population but believe that the vision of providing an integrated approach for Medicare-Medicaid Enrollees (MMEs) is vital to improving the quality and outcomes experienced by this complex population.

Creating systemic change as that proposed by SCDHHS for MMEs requires careful consideration of program roll out and we appreciate the deliberate approach the State has taken to garner stakeholder participation and feedback. We were pleased to be an active participant in the integrated advisory work group over the past year and continue to offer our national experience in shaping an effective, integrated, person-centered program for South Carolina's MMEs.

If I can be of assistance, please feel free to contact me. Thank you for your commitment to engage UnitedHealthcare and other health plans in meaningful dialogue. We look forward to the ability to shape a program that improves quality and reduces the costs associated with these individuals with complex needs.

Sincerely,

A handwritten signature in black ink that reads 'Dan Gallagher'.

Dan Gallagher
Plan President
UnitedHealthcare Community Plan

Si desea recibir una copia de esta información en español, llame al 1-800-414-9025 (TTY: 711).